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PLANNING FOR PROGRESS:

THE INITIAL REPORT

OF THE

MENTAL HEALTH CARE COMMITTEE

METROPOLITAN TORONTO DISTRICT HEALTH COUNCIL

MAY 1984

MENTAL HEALTH CARE COMMITTEE

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* to September, 1983

** Whitby Psychiatric Hospital April 1, 1984

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EXECUTIVE SUMMARY

In May 1982 the Minister of Health requested all District Health Councils to undertake a review of adult mental health services in their respective communities. The production of the Inventory of Adult Mental Health Services in Metropolitan Toronto constituted the first phase in this review. The second phase was the examination of adult mental health care needs in Metropolitan Toronto, and the development of a plan to meet those needs.

The method selected by the Mental Health Care Committee for use in the development of this plan was strategic planning.

Many previous studies have identified the mental health priority areas in Metro Toronto. The Committee chose to focus its planning on two of these areas: co-ordination of services, and crisis intervention.

The co-ordination of mental health services is an issue of prime importance for Metropolitan Toronto because of the great number of institutions, agencies, and organizations providing services, in addition to the complexity of the metropolitan structure - five cities and a borough. Mental health services in Metro Toronto have frequently been described as fragmented and a non-system. This situation has arisen because services have developed independently and without an overall plan to consult. As a consequence, there are gaps in services which result in hardship for the mentally ill.

The Mental Health Care Committee examined the area of co-ordination with the assistance of an internal advisory body, the Advisory Group on Co-ordination, and arrived at recommendations for a co-ordination model that will promote the development of a rational, co-ordinated mental health services system for Metro Toronto.

The other priority area chosen for examination, crisis intervention, is a crucial component of the mental health services system and an area of urgent need. The Mental Health Care Committee examined the crisis intervention resources available and considered the range of crisis services that should exist.

Recommendations point to an expansion in the types of crisis intervention resources available, with an emphasis on local community mental health services consultation in their development.

The recommendations are presented in the order in which they appear in the report.

CO-ORDINATION

RECOMMENDATION #1

a) That an ADVISORY GROUP ON THE CO-ORDINATION OF METROPOLITAN TORONTO MENTAL HEALTH SERVICES be established by the Metropolitan Toronto District Health Council as an internal advisory body to provide continuing advice to the Metropolitan Toronto District Health Council, and through it to the Ministry of Health, on the co-ordination of mental health services in Metropolitan Toronto. The objective is the achievement of a rational, co-ordinated mental health services system. (page 26)

b) That funding for staff resources to the Advisory Group on Co-ordination of Metropolitan Toronto Mental Health Services be made available by the Ministry of Health, in order to provide administrative support to the Advisory Group and to promote the successful development of co-ordinating bodies in those municipalities that do not currently have a co-ordinating agency. (page 28)

RECOMMENDATION #2

a) That each municipality within Metro Toronto be encouraged to establish a group with broad-based representation to function as a MUNICIPAL MENTAL HEALTH SERVICES CO-ORDINATING BODY, to encourage co-ordination at the local level and to assist the Mental Health Care Committee in the carrying out of its mandate. (page 29)

b) That local municipalities presently without mental health co-ordinating bodies apply for funding to the Ministry of Health to establish and maintain municipal mental health services co-ordinating bodies. (page 32)

CRISIS INTERVENTION

RECOMMENDATION #3

That in those municipalities identifying a mobile unit to provide on-site counselling and crisis resolution to adults in crisis situations as a local priority mental health service need, consultation be encouraged among local hospitals and community mental health agencies to develop a mobile unit, considering Youthdale's Crisis Support Team as one model. (page 66)

RECOMMENDATION #4

That in those municipalities identifying a crisis hostel for the temporary shelter of mentally ill adults from a stressful living situation as a local priority mental health service need, consultation be encouraged among local hospitals and community mental health agencies to develop such a crisis hostel. The Addiction Research Foundation's Detoxification Centres, each operated as a department of a general hospital, provide a useful model of safe accommodation, short-term support, and linkage with the appropriate services. The opportunity of using peer support - former psychiatric patients - should be encouraged in the staffing of the crisis hostel. (page 66)

RECOMMENDATION #5

a) That a Toronto Community Crisis Centre be established as recommended in The Mayor's Action Task Force Report on Discharged Psychiatric Patients, set up along the following lines: (page 67)

   1. In general, length of stay to be fewer than 7 days.

   2. The target clients are chronic psychiatrically disabled adults in crisis who lack supportive resources.

   3. A free-standing centre located in a house-form setting in downtown Toronto.

4. No more than fifteen beds be available in a comfortable, non-institutional environment.

5. The hours of operation be 7 days per week 24 hours per day, holidays and weekends included.

6. Funding from Ministry of Health, Community Mental Health Programs Branch.

7. Crisis Centre to be operated and managed by a Community Board responsible to the City of Toronto and the Ministry of Health.

8. Mandate be reviewed after three years of operation.

9. Quality of staff critical to effective operation.

10. One Psychiatrist on call at all times for medical emergencies, possible admission to hospital, and prescription of medication.

11. Strong links be forged with the general hospitals' Emergency Departments and psychiatric units as well as case managers.

12. Effective referral links be established and maintained to and from community services.

13. Part of preliminary process to included extensive training for staff with a view to gaining awareness of services available as detailed in the Metro Toronto District Health Council's Inventory of Adult Mental Health Services.

14. From the inception of the program a leased car and at least one staff member be available for mobile on site community problem intervention in the City of Toronto.

RECOMMENDATION #5

b) That liaison be established between the City of Toronto Municipal Planning Committee and the municipal mental health services co-ordinating body. (page 69)

RECOMMENDATION #6

That appropriate space and personnel be provided in the Emergency Department of each acute care general hospital for the treatment and observation of psychiatric emergencies. Appropriate personnel would include staff trained in crisis intervention methods and familiar with community mental health care resources. (page 70)

RECOMMENDATION #7

That the following University of Toronto teaching hospitals located in the downtown core of the City of Toronto develop a plan to co-ordinate their crisis intervention services: Hospital for Sick Children, Mount Sinai, St. Michael's, Toronto General, Toronto Western, Wellesley, Women's College, the Clarke Institute of Psychiatry and Queen Street Mental Health Centre. (page 70)

RECOMMENDATION #8

a) That the Ministry of Health provide funding for and encourage participation in a training program for general hospital psychiatric unit staff, regarding the management of disruptive, assaultive or out of control behaviour. As well a program should be considered for hospital emergency staff and community mental health services staff. (page 70)

b) That management guidelines or protocols be developed by each hospital regarding the response to threatening or violent behaviour by a patient in the psychiatric in-patient unit and the emergency department. (page 71)

RECOMMENDATION #9

That the Metropolitan Toronto District Health Council's Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services promote consultation and collaboration between the provincial psychiatric hospitals serving Metro Toronto and the general hospitals, to develop strategies to meet the service needs of the more difficult to handle psychiatric patient. (page 71)

RECOMMENDATION #10

That the University of Toronto Department of Psychiatry be commended for their initiative in establishing a co-ordinated Emergency Bed Registry and be encouraged to continue their work towards developing an example of co-ordinated psychiatric services in the teaching hospitals. (page 71)

RECOMMENDATION #11

That those acute care general hospitals having no designated crisis beds for brief hospitalization be requested to establish such beds. (page 72)

RECOMMENDATION #12

That the Metropolitan Toronto District Health Council's Advisory Group on the Co-ordination of Mental Health Services promote consultation between psychiatric facilities and community mental health agencies serving each municipality of Metropolitan Toronto to discuss solutions to the problem of the hospitalized patient who no longer requires in-patient acute intensive care but remains in hospital for lack of available alternatives. The suggested vehicle for this consultation is the recommended municipal mental health services co-ordinating body in each municipality. (page 72)

RECOMMENDATION #13

That those acute care general hospitals without an organized day treatment program give serious consideration to the need to establish such a service themselves or with other hospitals and/or community agencies, and receive appropriate funding from the Ministry of Health to provide this alternative to in-patient hospitalization. (page 73)

RECOMMENDATION #14

That the Ministry of Health encourage all psychiatric facilities serving Metropolitan Toronto to establish liaison with the Supportive Housing Coalition and work with them in negotiating contracts to provide adequate back-up support services for former psychiatric in-patients in crisis. (page 73)

RECOMMENDATION #15

That a Police-Ambulance Liaison Committee be initiated at Whitby Psychiatric Hospital, by the hospital, in order to provide a regular forum for the discussion of police, ambulance, and hospital service concerns, and in order to develop a mutual understanding and appreciation of police, ambulance, and hospital responsibilities. (page 74)

RECOMMENDATION #16

That the Ministry of Health update the 1978 guidelines provided by the Ministry to the Ambulance Service on "The Care and Transportation of the Emotionally Disturbed Patient" and provide direction regarding the definition of an "emergency" psychiatric patient. (page 74)

RECOMMENDATION #17

That an educational program funded by the Ministry of Health regarding the mentally ill be developed for Ambulance Services staff to allow them to expand their understanding of the behaviour of the mentally ill and thus improve their services to this patient group. (page 75)

RECOMMENDATION #18

That the Ministry of Health in co-operation with the Ministry of the Attorney General provide funding for the development of an educational program regarding mental illness for Metropolitan Toronto's Justices of the Peace to assist them in carrying out their functions under Section 10(1) of the Mental Health Act. (page 75)

FUTURE DIRECTIONS

RECOMMENDATION #19

That the Metropolitan Toronto District Health Council monitor and review developments regarding the planning and implementation of crisis intervention resources across Metro Toronto. (page 76)

RECOMMENDATION #20

That the Metropolitan Toronto District Health Council forge stronger links with the University of Toronto Department of Psychiatry in order to promote the mutual sharing of information regarding psychiatric services. (page 77)

RECOMMENDATION #21

That the Metropolitan Toronto District Health Council sponsor meetings of designated representatives of local hospitals and community-based mental health services in those municipalities that currently have no local co-ordinating body, to ensure that the provision of crisis intervention services is given serious consideration at the local level. (page 77)

RECOMMENDATION #22

That the Metropolitan Toronto District Health Council jointly sponsor meetings of designated representatives of local hospitals and community-based mental health services with the existing municipal mental health services co-ordinating bodies, to discuss the provision of crisis intervention services at the local level. (page 77)

RECOMMENDATION #23

That the Metropolitan Toronto District Health Council undertake additional analysis of the information regarding mental health resources collected for the Inventory of Adult Mental Health Services in Metropolitan Toronto, and share this information with the municipal co-ordinating bodies in order to assist them in establishing local priorities. (page 78)

RECOMMENDATION #24

That the Metropolitan Toronto District Health Council apply to the Ministry of Health for funding to regularly update the Inventory of Adult Mental Health Services intially published in the spring of 1983. (page 78)

GLOSSARY

A. **The Psychotic Disorders:** Characterized by profound disturbance, disability, loss of contact with reality, sensory dysfunctions, and lack of insight.

1. **Affective Disorders** - psychoses marked by extreme disturbance of mood. Includes manic-depressive psychosis, psychotic depression, and involutional melancholia.

2. **Paranoid Disorders** - psychoses involving thought disturbances of a persecutory nature but where gross personality disturbance is absent. Includes paranoia, and the paranoid states.

3. **Schizophrenia** - psychoses characterized by withdrawal, disturbance of emotions, autistic thinking, bizzare behavior, sensory disturbances, speech and thought disturbances.

B. **The Psychoneurotic Disorders:** Characterized by awareness of anxiety, fair adjustment to life, overreliance on defenses, some insight.

1. **Traumatic Neuroses** - neuroses precipitated by extreme stress or catastrophic experiences in an otherwise normal person.

2. **Anxiety Reaction** - neurosis marked by extreme apprehension and feelings of imminent danger; the exception to the rule that neurotics are noted for their defense mechanisms since the anxiety reaction appears to have none.

3. **Hypochondriasis** - neurosis involving excessive preoccupation with somatic functions, mostly a fear of developing ill health.

4. **Conversion Reaction** - neurosis characterized by the manifestation of somatic symptoms without any identifable organic cause.

5. **Dissociative Reactions** - neuroses involving disturbances of consciousness and memory. Includes amnesia, fugue states, somnambulism and multiple personality.

6. **Phobias** - neuroses involving the presence of irrational, excessive fears.

7. **Obsessive-Compulsive Neurosis** - neurosis in which unwanted, intrusive thoughts or actions must be repeated.

8. **Reactive Depression** - neurosis involving depression precipitated by an unhappy life experience.

C. **The Conduct Disorders:** Characterized by behaviors that violate the codes of conduct of the society.

1. **Antisocial Reactions** (psychopathic personality) - disorders marked by emotional immaturity, lack of responsibility and poor judgment, absence of moral values, inability to learn from experience or to postpone gratification.

2. **Dyssocial Reactions** - disorders characterized by strong loyalties to subgroup values which conflict with the larger societal values.

3. **Addictions** - alcoholic addiction involves the excessive intake of alcohol, dependence on alcohol to the extent of leading to disruption of social, economic functioning and health. Drug addiction involves the repeated reliance upon drugs associated with physical or psychological dependence.

4. **Sexual Deviations** - disorders in which the gratification of the adult sexual need is obtained through practices other than intercourse with a genitally mature person of the opposite sex who has reached the legal age of consent.

From: R. Suinn, Fundamentals of Behavior Pathology (New York: John Wiley & Sons, Inc., 1970), pp. 503-504.

SECTION I

1. INTRODUCTION

Mental illness is a problem of major proportions, using any measure. The following facts have been well publicized:*

- One of every eight Canadians can expect to be hospitalized for mental illness at least once.
- Mental illness is the second leading cause in general hospital use among those aged 20 to 44.
- Suicide is the second most frequent cause of death among Canadians aged 15 to 39.
- Operating expenditures for patients being treated for mental illness in psychiatric facilities and general hospitals in Canada have been estimated at $1 billion.
- Mental illness is the leading cause of hospital and medical care in the most economically productive part of the population, those persons aged 20 to 64.

The toll taken in Canada by mental disorders in comparison to other medical conditions may be seen in Figure 1.

In Metropolitan Toronto, mental disorder is the fourth most common cause of general hospital use for "working age" males (20-64 years), and the fifth most common cause for "working age" females. In 1982-83, the total number of psychiatric patient-days in psychiatric and general hospitals serving Metropolitan Toronto amounted to 721,793. [2]

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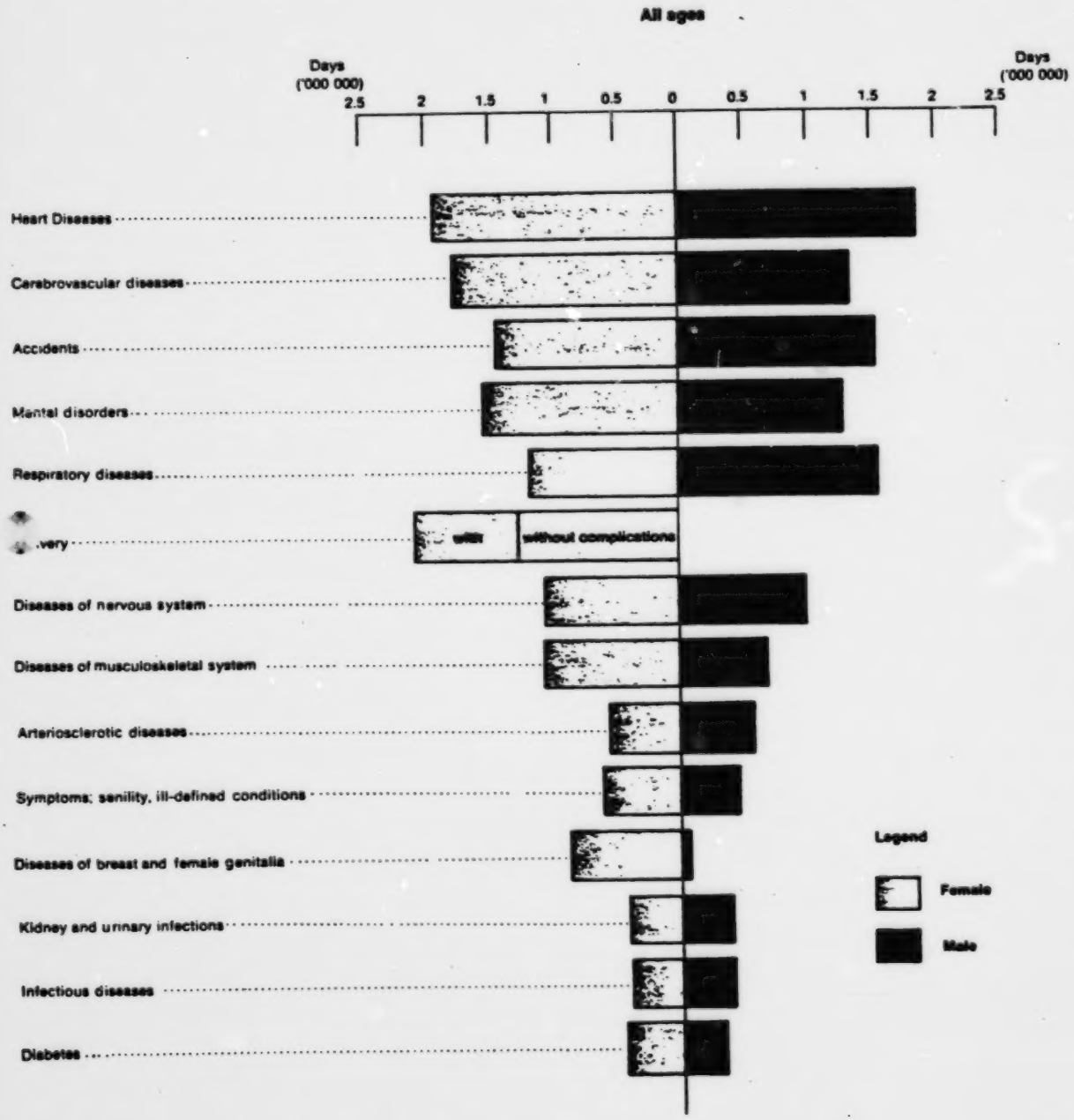
* Data in the pamphlet, "One of Eight", published in 1981 by Statistics Canada in collaboration with the Canadian Mental Health Association

Figure 1:

Patient-days by Major Causes, General and Allied Special Hospitals, by Sex, Canada, 1977*



* Does not include the 2,530,995 patient-days in mental institutions in 1977

Source: Institutional Care Section, Health Division, Statistics Canada

The most important causes of hospitalization for mental illness in psychiatric and general hospitals in the Metropolitan Toronto area are as follows: (1982-83)

Schizophrenia -	31.4% of psychiatric patient-days;
Affective Psychoses -	12.1% of psychiatric patient-days;
All Other Psychoses -	13.2% of psychiatric patient-days;
Neuroses -	10.3% of psychiatric patient-days.

The leading diagnoses of persons being discharged from psychiatric facilities in the Metro Toronto area are psychoses. Schizophrenia, affective psychoses, alcohol psychoses and other psychoses account for 42.1%. [3] Neuroses is the second most frequent diagnoses, accounting for 23.3% of all diagnoses on discharge.

A major change has taken place in the care of the mentally ill over the last two decades: the process of deinstitutionalization. This process has been defined as involving:

1. the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment;

2. the release to the community of all institutionalized patients who have been given adequate preparation for such a change; and

3. the establishment and maintenance of community support systems for non-institutionalized people receiving mental health services in the community. [4]

Two important developments paved the way for deinstitutionalization to begin: the adoption of new psycho-social methods of treatment in the mental hospital, and the introduction of new tranquilizer drugs which contributed significantly to the effective treatment and management of many psychotic patients. [5]

Deinstitutionalization as defined, however, has not as yet been fully put into practice. What has occurred is a decrease in the number of patients in mental institutions. In Ontario, for example, in 1960 there were 19,507 patients "on the books" of provincial psychiatric hospitals; by 1976 this had decreased to 5,030, and by 1982 to 4,514.[6] The number of patients treated in psychiatric units of general hospitals during this period increased as the locus of patient care became the patient's home community. In 1965 there were 617 patients "on the books" of general hospital psychiatric units in Ontario; by 1976, there were 1,789, and by 1982, 1,760.[7]

During 1982-83, there were 17,130 discharges from psychiatric facilities serving Metropolitan Toronto.[8]

During this period of rapid change, support programs for discharged psychiatric patients in the community have grown very slowly. As a result, the discharge of the mentally disabled to inadequate community resources has been the subject of wide-spread criticism.

It has been emphasized that communities are not going to continue to accept mentally disordered people in their midst if there are not appropriate community resources in place with which to deal with crisis situations as they arise. If we are unable to provide these resources, we encourage community rejection and increase the pressure for institutionalization.

2. BACKGROUND

Mental health care is a high priority for the Metropolitan Toronto District Health Council. Its importance is demonstrated by the fact that mental health care is the focus of one of the Council's four operational committees: the Mental Health Care Committee.

In recent years, mental health care has also become a top priority for the Ministry of Health. Public awareness of and interest in mental health issues have been encouraged by increased attention to this area by the Ministry. In May, 1982, the Minister of Health requested all District Health Councils to undertake a review of adult mental health services in their respective communities. As well, in response to the challenge of developing some cohesion in services provided by the various Ministries involved in support to the mentally ill, the Ministry of Health assumed the role of "lead ministry" for all matters relating to adult mental health care. Currently, "the restructuring of mental health services to create a comprehensive community-based range of programs" is a top priority within the Ministry of Health. [9]

The Metropolitan Toronto District Health Council has an important role to play in the development of a local mental health care system that reflects Metroplitan Toronto's needs, and Metropolitan Toronto's priorities. Council's mandate is to provide advice to the Minister of Health in the planning and co-ordination of health care services for the citizens of Metro.

In order to fulfill this responsibility in the area of mental health, the Metropolitan Toronto District Health Council receives recommendations from the Mental Health Care Committee. The Committee consists of Council members with an interest or expertise in the area of mental health, plus additional mental health experts, including consumers. The terms of reference of the Mental Health Care Committee were approved by Council in December 1982 as follows:

MENTAL HEALTH CARE COMMITTEE

TERMS OF REFERENCE

1. To develop principles for a system of adult mental health services for Metropolitan Toronto.

2. To develop and analyze an inventory of adult mental health services in Metropolitan Toronto to be used as a data base in health care planning.

3. To develop a plan for a rational, co-ordinated mental health system, and to recommend to the Metropolitan Toronto District Health Council how the plan should be implemented.

4. To review and make recommendations to the Metropolitan Toronto District Health Council on Adult Community Mental Health Programs annually.

3. NATURE OF THE PROBLEM

The planning of mental health services in a district of the size and complexity of Metropolitan Toronto is a problem of considerable dimensions. Metropolitan Toronto has a population of 2,137,395 (1981 census) and is composed of five cities - Etobicoke, North York, Scarborough, Toronto, York - and a borough, East York. Each of these municipalities has its own municipal government, belongs to the metropolitan government, and each has its own Board and Department of Health.

There are over 100 community-based adult mental health programs serving the needs of the citizens of Metropolitan Toronto, offered by more than 60 community agencies. In addition, there are 19 acute care general hospital Departments of Psychiatry, 2 Provincial Psychiatric Hospitals, and a psychiatric institute, each offering numerous programs. (See map on following page.)

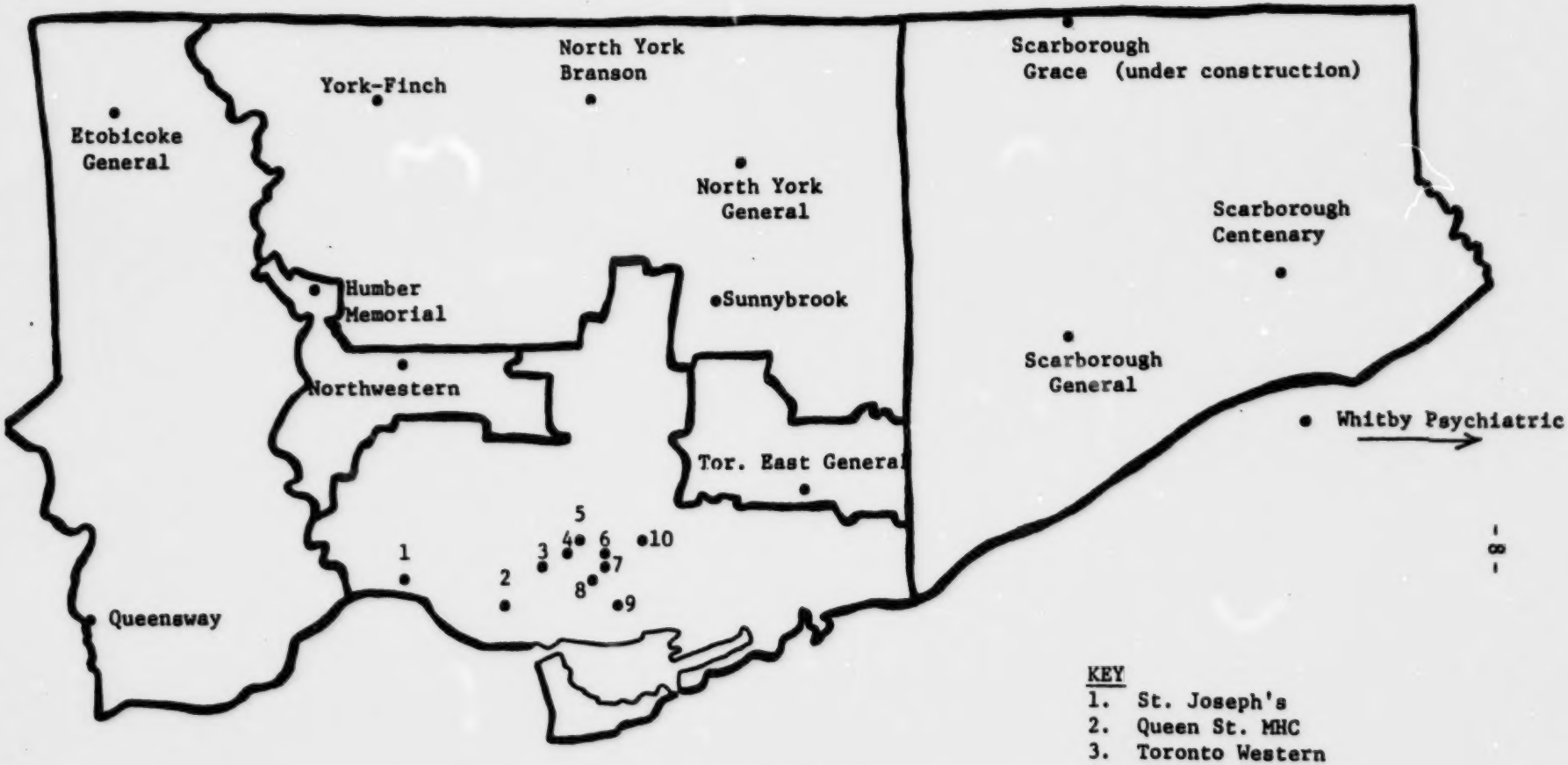
The Inventory of Adult Mental Health Services in Metropolitan Toronto, prepared for the District Health Council by Community Resources Consultants of Toronto in the Spring of 1983, was a major undertaking, and describes the many out-patient mental health services available. When the services are categorized geographically, by municipality, the inequity in the distribution of resources is apparent. (See Appendix, p. A - 35)

This inventory constituted the first phase of the review of adult mental health services requested by the Minister of Health. An examination of adult mental health care needs and the development of a plan to meet those needs were tasks accruing to the Adult Mental Health Services Research Project.

3.1 Strategic Planning

In order to develop an overall plan for meeting adult mental health care needs, a method or framework for planning was necessary. The method selected by the Mental Health Care Committee was strategic planning.

GENERAL HOSPITALS WITH PSYCHIATRIC UNITS AND PSYCHIATRIC HOSPITALS SERVING METROPOLITAN TORONTO



Population Metropolitan Toronto (1981 Census) 2,137,395.

KEY

1. St. Joseph's
2. Queen St. MHC
3. Toronto Western
4. Doctors Hospital
5. Clarke Institute
6. Women's College
7. Toronto General
8. Mount Sinai
9. St. Michael's
10. Wellesley

The processes involved in strategic planning may be divided into three main sections: an analysis of the present situation, a statement of long term goals, and a description of intermediate tasks. Put simply: what we have, what we want, and how to get there. *

Viewed schematically, this outline of long range planning is presented in Figure 2. Applied to the mental health services system, we have at the left the present disarray of mental health service system components, and at the right, the desired array of system components. Between these two ends lies the area of focus of strategic planning, consisting of a series of programs.

In the ideal planning situation, one first sets long term goals, then develops and implements individual programs whose objectives are in accordance with those long term goals. This process has the consequent result of a whole system which exemplifies the desired goals. However, this situation assumes a completely bare field at the onset of planning.

In reality, planning cannot ignore the constructions that already exist in an area. Whether help or hindrance, they must be taken into account and considered in the planning. In this way, a long range plan can be seen as analogous to a blueprint for a creative renovation or remodelling, rather than a blueprint for an entirely new structure.

For this reason, the process of strategic planning begins with an analysis of the present situation. The setting of long term goals is another vital step. The development of principles to be exemplified in these long term goals contributes to the process of goal setting.

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* cf., the strategic planning process as described in Health Care, the 80's and Beyond: Seeking Consensus, Ontario Ministry of Health, 1983, p.5

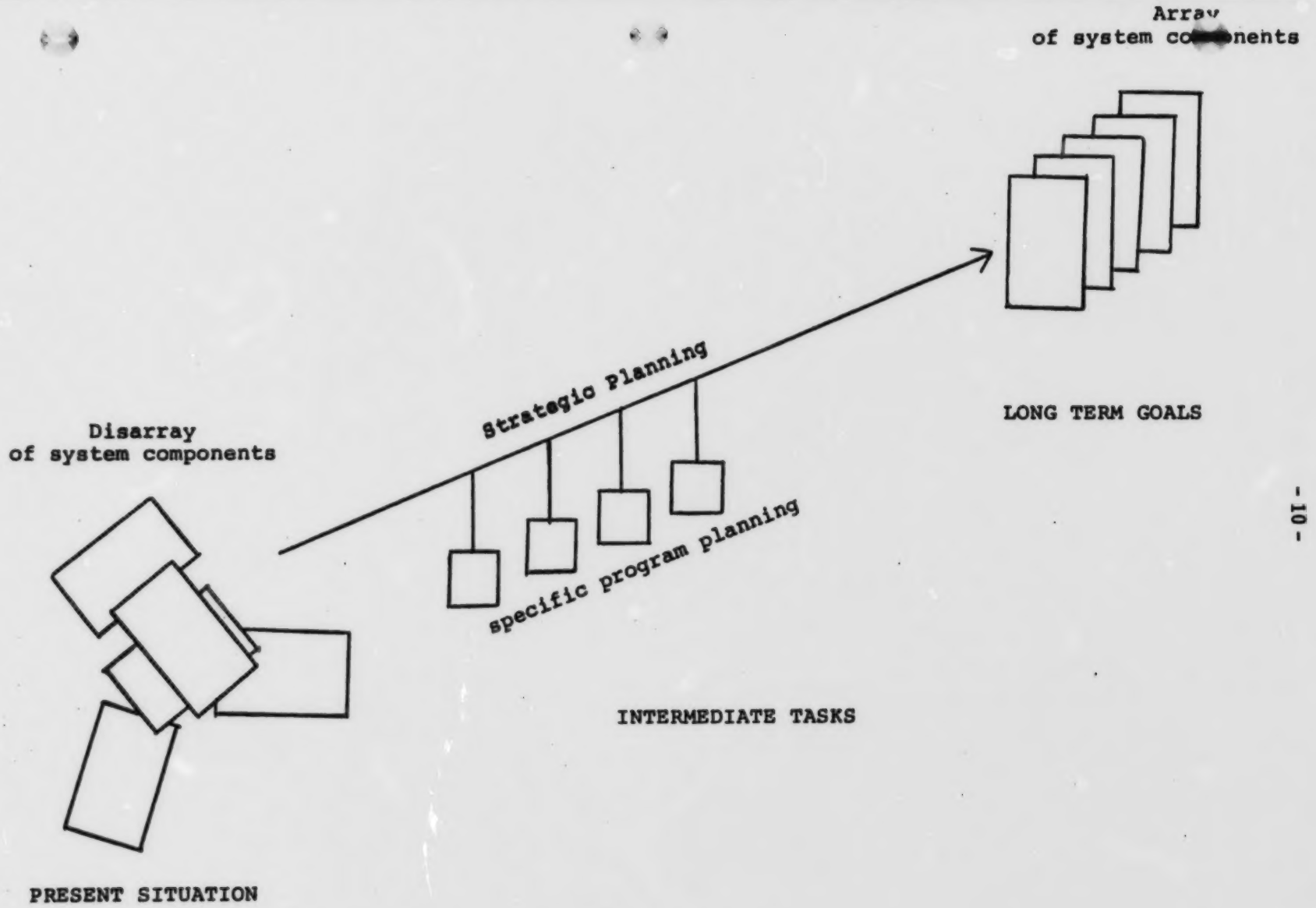

FIGURE 2: STRATEGIC PLANNING

3.2 Principles of a Comprehensive Mental Health Service System

In any attempt to assess the adequacy of the mental health services system - to determine gaps or overlaps - it is necessary to envision what a comprehensive mental health services system would look like. Before such a system can be envisioned, however, the principles the system is to exemplify must be articulated. The Mental Health Care Committee agreed on the following principles: *

MENTAL HEALTH SERVICES PRINCIPLES

Certain guiding principles should direct the course of the development of a mental health services system and be reflected in the services offered. These basic guiding principles are considered to be comprehensiveness, balance, non-discrimination, personal dignity and self-determination. A comprehensive range of services should be broad enough to accommodate the diverse and changing needs of each client, and should demonstrate a balance among the variety of services in the system. All basic services and opportunities should be offered to those who need them, without regard to race, colour, creed, sex, or national origin. Services should be provided in an environment and in a manner that protects personal dignity and privacy; records of clients should be confidential. Clients of the system should retain the fullest possible control over their own lives, setting their own goals and participating in planning to achieve those goals.

SERVICE DELIVERY PRINCIPLES

1. Co-ordination - The disparate components of the system should be brought together and made to work for the benefit of the client. This requires leadership to develop new opportunities and services where gaps have been identified, and to assure client access to the opportunities and services that already exist. An integral part of this co-ordination of system components is communication, the mutual sharing of information.

2. Availability & Access - Clients should find it easy to use the services. Outreach programs should be provided to assure that services reach those most in need of assistance.

---

* These principles are based to a large extent on those outlined in the U.S. National Institute of Mental Health's Definitions and Guidelines for Community Support Systems, 1977. Similar principles to be followed in the construction of effective service delivery networks have recently been succinctly described in 10 propositions by Dr. S.J. Freeman of the University of Toronto. (See Appendix I.)

3. Evaluation & Flexibility - Services should have stated objectives and criteria, and should be evaluated regularly. Services should change as necessary to remain responsive to their clients' needs.

4. Developmental Programming - Clients should be treated as developing persons capable of growth (or of slowing of deterioration). Opportunities and incentives should be provided for clients to increase skills.

5. Most Appropriate Setting - Services should be offered in the least restrictive and most appropriate setting in which it is possible to:

   a) assure the safety both of the clients and those with whom they come in contact;

   b) ensure the appropriateness and adequacy of services; and

   c) provide services which optimize the functioning of the individual.

   Gradual opportunities should be available for a client to assume new responsibilities, through a continuum of services at varying degrees of independence. The transition along this continuum should be smoothed for the client, the family or significant others, and for the community. Services should occur in the natural setting and/or as close to home as possible.

6. Continuity of Supportive Relationships - Services should be organized to avoid unnecessary disruptions in relations between staff and clients, and to promote the long-term availability of one or more helping persons who know the client well and whom the client respects and trust.

7. Integration - For the most part, mentally disabled persons should be accommodated throughout the community, rather than being segregated into institutional settings. Work and leisure time programs should be integrated into or generally consistent with normal routines and rhythms of life in the client's community. Names of programs and service settings should minimize stigma.

8. Natural Support System - Clients should be encouraged to assume increasing responsibility for solving their own problems; service workers should avoid the tendency to take over responsibilities that the client or his family and friends might be able to perform. Also, service workers should actively support the client's family and friends in coping with stress related to the client's disorder. Whenever possible, service workers should foster informal mutual self-help networks for their clients.

9. Public Education - Public education programs should be used to challenge negative stereotypes and myths about mentally disabled persons.

10. Community Involvement - The ideas of citizens and consumers in the particular locale should be taken into account in the planning and evaluation of community services. Service providers should make the community aware they welcome hearing these ideas.

The "Mental Health Services Principles" received the approval of the Metropolitan Toronto District Health Council on April 13, 1983.

3.3 Priority Areas

Because of the number of studies that have already been done on the mental health needs of Metropolitan Toronto, the Mental Health Care Committee decided to build on this body of work rather than carry out yet another needs assessment in order to arrive at mental health priority areas. The findings of studies which have identified the issues, problems, and gaps in mental health services in Ontario and Metropolitan Toronto are presented in chart form in Figure 3. (Only those areas of concern dealt with in the recommendations of three or more of the reports are included. [10])

The studies reported on are:

The Canadian Mental Health Association/Metro:
"The Report on Psychiatric Services in Metropolitan Toronto", 1977.

Hospital Council of Metropolitan Toronto:
"Adult Mental Health Services Report", 1979.

Ontario Council of Health, Committee on Mental Health Services in Ontario:
"Agenda for Action", 1979.

Supportive Housing Coalition:
"Community Housing for Consumers of Mental Health Services in Metropolitan Toronto", 1979.

Peat, Marwick and Partners:
"Queen Street Mental Health Centre, Report: An Organizational Review", 1982.

City of Toronto/Supportive Housing Coalition:
"The Housing Gap: Deficiencies in Appropriate Housing for Ex-psychiatric Patients", 1982.

Ontario Public Service Employees Union/Marshall:
"Madness: An Indictment of the Mental Health Care System in Ontario", 1982.

Heseltine et al.,
"Background Paper on the Future Development of Whitby Psychiatric Hospital", 1982.

	1977 CMHA	1979 HCMT	1979 ONT. COUNCIL OF HEALTH	1981 SUPP. HOUSING COALITION	1982 PEAT MARWICK	1982 CITY/TOR. SUPP. HOUS. COALITION	1982 OPSEU	1982 HESELTINE
PRINCIPLES								
Co-ordination	X	X	X	X	X	X	X	X
Continuity of Care		X	X		X		X	X
Co-operation	X	X			X	X	X	
MORE & BROADER SERVICES								
Crisis Intervention			X	X		X		X
Housing - Supportive	X	X		X		X	X	X
Rehabilitation and Vocational/Educational		X	X				X	X
Social/Recreational	X	X					X	
Financial Assistance			X			X	X	
MORE EMPHASIS ON SPECIAL GROUPS								
Alcohol & Drugs		X	X					X
"Secure" Units					X		X	X
Data Base	X		X		X	X		
Needs Assessment	X	X	X					
Patients' Rights	X		X				X	

FIGURE 3: RECOMMENDATIONS FROM PREVIOUS STUDIES

These reports completed in the recent past have consistently identified certain priority areas: supportive housing, aftercare, co-ordination of services, co-operation, data base development, continuity of care, and crisis intervention.

Through the Adult Mental Health Services Research Project, the Mental Health Care Committee was provided with the resources to conduct a detailed study of selected components in the present mental health care system. In accordance with the process of strategic planning, this focussed study was initiated to provide the information necessary to enable specific program objectives and recommendations to be formulated in identified priority areas.

Some of the individual areas of most pressing concern in the previous studies have been the subject of specific reports. Housing is an example, having been the subject of at least four recent reports [11]. Supportive housing has subsequently been recognized as a priority area, and the Ministry of Health has funded programs in this field. A great deal of work is continuing in this area under the direction of the Supportive Housing Coalition, an alliance of agencies and individuals organized to advocate for, develop, and implement supportive housing options.

Similarly, aftercare - encompassing vocational/educational services, social recreational services, medical/therapeutic services as well as housing - has been rigorously explored in "Psychiatric Aftercare in Metropolitan Toronto". [12] This is an excellent study, distinguished by its emphasis on interviews with discharged psychiatric patients. The area of aftercare services has been recognized as a priority, and new programs have recently been introduced by the Ministry of Health. One example is the case manager program being established in the Parkdale area of Toronto, with 10 case managers, a team co-ordinator, and support staff. A budget of $430,000 has been allocated to this new aftercare program which will link former patients to community services.

However, some areas of wide-spread concern, as identified by the reports, were still awaiting action. This situation occurred for various reasons. With regard to three of the major areas of concern, co-ordination, co-operation, and data base development, no organization with the necessary mandate and capability to act

was in existence. With the development of the District Health Council, however, the possibility became ripe for a plan of action in these areas. Accordingly, three of the options for research presented for consideration as the study focus of the Adult Mental Health Services Research Project centered on: co-ordination (of services and planning), co-operation (of agency, hospital, and community) and data base development.

Another area of demonstrated major concern was crisis intervention. Part of the reason why progress has been slow in this area may be attributed to the variety of interpretations give to the term "crisis intervention". This issue was presented to the Mental Health Care Committee as the fourth study focus option.

Continuity was yet another area identified as a major concern; this term, as with "crisis intervention", suffers from a lack of clarity and consensus in its use. However it is used though, the concept of continuity assumes both the availability and accessibility of a wide array of resource services in the community. The continuity of care provided by Metropolitan Toronto's mental health services system was presented as a fifth study focus choice.

The decision of the Mental Health Care Committee was to focus the Adult Mental Health Services Research Project on two identified priority areas for action: co-ordination and crisis intervention. By choosing to commence its work in these two areas, the Committee recognized the critical importance of co-ordination for Metropolitan Toronto, and the urgency of crisis intervention needs.

SECTION II

4. CO-ORDINATION

Co-ordination is vital in the development of a comprehensive mental health services system. A co-ordinated system does not just happen; it must be planned. In choosing to focus the Research Project on co-ordination, the Mental Health Care Committee acknowledges the role of co-ordination in creating and maintaining the mental health services system.

Co-ordination and system development are distinct but related concepts. In the case of mental health, "system" refers to the development of regular or patterned activities between mental health service organizations (as well as other human services agencies). "Co-ordination" is the means by which such a system is developed. [13] The means for co-ordinating organizations can include such diverse mechanisms as informal staff contacts, written agreements, and ongoing formal policy councils.

The co-ordination of mental health services is an issue of prime importance for Metropolitan Toronto because of the great number of institutions, agencies, and organizations providing services, in addition to the complexity of the metropolitan structure - five cities and a borough. Mental health services in Metro Toronto have frequently been described as fragmented, and a non-system. This situation has arisen because services have developed independently and there has been no overall plan to consult. As a consequence, there are gaps in services which result in hardship for the mentally ill. A conspicuous gap is the lack of an adequate range of services for the chronically mentally ill patient.

A comprehensive mental health services system may be envisioned as comprising the following components:

Hospitalization	Crisis Intervention	Supportive Housing
Discharge Planning	Continuity of Care	Financial Assistance
Partial Hospitalization	Co-operation	Vocational Training
Day Treatment	Co-ordination	Social/Recreational Programs
Out-Patient Treatment	Data Development	Case Management

Back-Up Support
Identification of the Population-at-risk
Prevention

One of the prime benefits of the model presented is that it recognizes the less visible components of a comprehensive system. These less visible components are co-ordination, co-operation, continuity of care, and data base development. The importance of these components must not be under-estimated, since their absence results in the fragmentation of services; as previously noted, this is a common criticism of the present Metropolitan Toronto mental health services situation.

It is clear that a means of co-ordination is vital to develop the present fragmented care capacity into an effective system. A study of co-ordination in Metropolitan Toronto sought to conduct:

- an examination of the co-ordinating bodies in Metro;
- an examination of the types of co-ordination present in mental health services;
- an examination of the hospitals' views of co-ordination; and
- an examination of the community agencies' views of co-ordination.

4.1 Study Approach

The following methods were utilized to carry out the study of co-ordination in Metropolitan Toronto:

1. Review of the literature.
2. Analysis of information collected via the "Inventory of Adult Mental Health Services" questionnaire.
3. Interviews with the co-ordinating bodies.
4. Interviews at all 19 acute care general hospitals.
5. Interviews with selected community mental health services.
6. Interviews at all 6 municipal departments of public health.
7. Interviews at the Clarke Institute of Psychiatry.
8. Interviews at the 2 Provincial psychiatric hospitals.
9. Observation at co-ordinating groups' meetings.
10. Establishment of an Advisory Group on Co-ordination.

4.2 Findings

Initial findings indicated that there are three co-ordinating bodies that serve to facilitate the co-ordination of mental health services Metro-wide: the Canadian Mental Health Association/Metro (CMHA/Metro), Community Resources Consultants of Toronto (CRCT), and the Metropolitan Toronto District Health Council (MTDHC).

The Canadian Mental Health Association/Metro is a voluntary organization involved in community development, public education, advocacy, and direct services. Volunteer boards called mental health councils have been established in all municipalities to identify needs and initiate programs. CMHA/Metro has played a leading role in the development of community-based mental health services, and its joint projects with other agencies serve as an example of inter-agency co-ordination. CMHA/Metro has assumed leadership in the bringing together of agencies from across Metropolitan Toronto around certain mental health issues such as supportive housing. Although CMHA/Metro has achieved some success in organizing agencies around certain issues, it has no defined mandate for co-ordination.

Community Resources Consultants of Toronto is a "service for services", providing information about mental health resources as well as consultation to mental health professionals. CRCT's functions have included bringing together mental health workers for purposes of improving communication, problem-solving, and lobbying for change. While CRCT has been involved in achieving some co-ordination of activities of mental health services, it does not have a defined mandate for co-ordination.

The Metropolitan Toronto District Health Council is the only Metro-wide co-ordinating body that has a mandate from the Ministry of Health to plan and co-ordinate local health care services.

In order to assist the Mental Health Care Committee to address the issue of co-ordination, an Advisory Group on Co-ordination was proposed to the District Health Council for approval.

4.3 Advisory Group on Co-ordination

Council approved the formation of the Advisory Group in September, 1983, with the following Terms of Reference:

1. As requested by the Mental Health Care Committee, to consider and make recommendations on model(s) for co-ordination of a system of mental health services in Metro.
2. To develop a mechanism for an ongoing communication network among mental health service providers to improve service delivery for patients in the system.

Members were sought from organizations actively involved in promoting co-ordination, and efforts were made to obtain representatives from each of the six municipalities that constitute Metropolitan Toronto.

The following organizations and municipal co-ordinating groups were requested to provide working representatives on the Advisory Group on Co-ordination: North York Inter-Agency Council Mental Health Sub-committee, Etobicoke Mental Health Services Agency, York Interagency Network, East York Interagency Network, Scarborough Agencies Federation, City of Toronto, Canadian Mental Health Association, Community Resources Consultants of Toronto, Ministry of Health, Association of General Hospital Psychiatric Services, Queen Street Mental Health Centre and Whitby Psychiatric Hospital.

Dr. Donald A. Wasylenki, a member of the Mental Health Care Committee, agreed to serve as Chairman. The membership of the Advisory Group on Co-ordination appears as Appendix II. The Advisory Group met formally on five occasions over a period of four months, from September to December, 1983.

The Advisory Group on Co-ordination agreed that the aim of a co-ordination model for Metropolitan Toronto should be to improve services for those most in need, the chronically mentally ill. (See Appendix III: "The Mentally Ill in Metropolitan Toronto".) The target population for the co-ordination would therefore be those organizations involved in providing services to the chronically mentally ill. It was further agreed that if an effective structure could be developed for this target population it would likely evolve to consider the entire range of mental health services.

Co-ordination may be aimed at various levels of service delivery; for example, the individual client level, the agency level, the system level. Although co-ordination is necessary at all levels, there was agreement that it was to the system level that the Advisory Group should address itself.

The definition of co-ordination used in the Clarke Institute of Psychiatry Consulting Group's report on Systems Co-ordination for Psychiatry Services in Toronto was introduced:

> "Co-ordination involves a process of concerted decision making or action in which 2 or more organizations participate with some sort of deliberate adjustment to one another to achieve a common goal".[14]

There was agreement that a co-ordination effort should strive to get the current available services working together more effectively.

The Advisory Group heard presentations regarding current co-ordination in each of the six municipalities of Metropolitan Toronto, and the document illustrating the resources to be co-ordinated within each municipality was examined. (See Appendix IV: "Mental Health Resources to be Co-ordinated: A Geographic Distribution".)

Issues derived from the literature on co-ordination were presented and discussed by the Advisory Group, as were issues from the experiences of the Advisory Group members themselves. The literature indicates that:

- a co-ordination model should build on the structures and processes already present.
- the range of services to be co-ordinated should be broad enough to include not only specialized mental health services, but also those non-specialized human services used by the mentally disabled.
- service providers directly affected by changing co-ordination patterns should be included in the planning of co-ordination models.
- co-ordination models should deal with specific identified problems.
- different mechanisms may be appropriate for co-ordinating different levels of the service delivery system; i.e. the individual client level, the agency level, the system planning level.

Several co-ordination models were discussed over the course of the Advisory Group's meetings: the Greater Vancouver Mental Health Services, the Mental Health Planning Board of Metropolitan Halifax - Dartmouth, the pivotal hospital concept, and the Clarke Institute of Psychiatry Consulting Group's systems co-ordination model. Summaries of these models are presented in Appendix V. The applicability of each of these models to the Metropolitan Toronto situation was examined.

The findings of the Advisory Group on Co-ordination principally involved the existing level of organization with regard to co-ordination of mental health services in each of the municipalities.

A major finding, as noted below, was that of the responsiveness of municipal groups to the MTDHC's initiative in convening an advisory group to develop a co-ordination model. This responsiveness was seen as a demonstration of the fact that co-ordination of mental health services is widely recognized as an urgent need.

The Advisory Group noted:

- In the City of York, a mental health sub-network has been established within the York Interagency Network. This mental health group was formed as a direct result of the MTDHC's request for a York representative on the Advisory Group on Co-ordination.

- In the City of Scarborough, an initiative in bringing together a mental health services co-ordinating group has been undertaken through the Scarborough Department of Health. Considerable interest has been demonstrated by Scarborough mental health service providers in establishing a co-ordinating group.

- In the Borough of East York, the Medical Officer of Health agreed to explore the possibility of forming a co-ordinating group.

- There are various co-ordinating groups around the City of Toronto, but they tend to be ad hoc and informal. Also, in one area of the city, there is the

Mental Health Program Placement Service (formerly entitled the Parkdale Mental Health Co-ordination Service) which, it appears, will primarily promote co-ordination services in Toronto where there are a large number of institutional, as well as community, services. The Advisory Group agreed that the municipal level of the City of Toronto would be an appropriate body to approach to suggest the convening of a meeting to examine the possibilities of a co-ordination initiative for the City's mental health services. In the City of Toronto, as in the other municipalities, the co-ordination model developed should build on the structure and processes already present.

- Two municipalities currently have formalized mental health services co-ordinating bodies: the City of North York has the Mental Health Sub-committee of the North York Inter-Agency Council; the City of Etobicoke has the Etobicoke Mental Health Services Agency. (See Appendix VI for descriptions of these two co-ordinating bodies.)

The Advisory Group on Co-ordination found that no central structure exists to which the various municipal co-ordinating bodies can relate. Also, there is no continuing mechanism whereby the Mental Health Care Committee can receive input from municipal bodies.

The Advisory Group recommended that the MTDHC establish an internal advisory body to provide continuing advice to the Council, and through it to the Ministry of Health, on the co-ordination of mental health services in Metropolitan Toronto. This would be the "Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services".

The Advisory Group also recommended that each municipality within Metropolitan Toronto be encouraged to establish a group with broad-based representation to function as a "municipal mental health services co-ordinating body".

The Report of the Advisory Group on Co-ordination appears in its entirety as Appendix VII. (Blue pages)

The Report of the Advisory Group on Co-ordination was submitted to the Mental Health Care Committee in February 1984, and received the Committee's support.

4.4 Community Consultation

A discussion document was subsequently developed, based on the Report of the Advisory Group, and was widely circulated to mental health service organizations across Metropolitan Toronto. (See Appendix VIII for the discussion document and the list of organizations contacted.)

Comments regarding the proposed co-ordination model were requested. Through this process, the Mental Health Care Committee sought consultation with those mental health organizations whose co-operation is vital for the development of a co-ordinated system.

Of 53 organizations requested to comment on the proposal, 24 responded. The majority expressed support for the co-ordination model proposed. Some of the comments received were:

> "I am indeed pleased that such a formal model, under the District Health Council, is developing to co-ordinate such important services". - City of Etobicoke Health Department.
>
> "It is with much relief that I find a sensible solution to this problem (of co-ordination) in the two recommendations". - Whitby Psychiatric Hospital.
>
> "Our committee fully supports and endorses in principle the proposed two-tier co-ordination system being recommended". - North York Inter-Hospital Committee.
>
> "We would suggest that the proposed model for co-ordination as suggested in the Discussion Paper of February 1984 be implemented". - Mount Sinai Hospital.
>
> "We applaud your initiative and are excited about prospects that can emanate from this proposal". - Community Occupational Therapy Associates.

There were some concerns expressed, however, mainly around two points: the composition of the proposed Advisory Group and the issue of authority. Several respondents urged that the Metro-wide co-ordinating bodies be represented on the Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services. The issue of the authority of the co-ordinating structures proposed was raised by several respondents as well. The point was made that the actual authority of the committees was not outlined.

After thorough discussion, the Mental Health Care Committee decided to accept as the nucleus membership of the proposed "Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services", the membership as originally suggested. This membership was supported in order to maintain the influence of the local co-ordinating bodies in the proposed Metro-wide "Advisory Group".

On the second point, the authority of the proposed co-ordinating structures, the following seems clear: in that the proposed structures would be assisting in the carrying out of the MTDHC's mandate, they would share in that mandate, which is the formulating of advice to the Minister of Health.

4.5 Conclusions and Recommendations

A co-ordination model for Metropolitan Toronto is needed that will provide:

1. ON THE METRO LEVEL:

   - a means of communication and information-sharing among municipal co-ordinating groups,
   - a conduit for advice on co-ordination issues to the Mental Health Care Committee (and thence to the Council and Ministry of Health),
   - a forum for discussion of Metro-wide issues,
   - a mechanism for identifying and prioritizing Metro-wide mental health needs,
   - a mechanism to assist the Mental Health Care Committee in regionalized planning for special services.

2. ON THE MUNICIPAL LEVEL:

- o a means of identifying local mental health needs,
- o a means of indicating local mental health priorities,
- o a forum for discussion of local mental health issues,
- o a means of communication and information-sharing between local agencies,
- o a mechanism for fostering the co-operative development of strategies for meeting identified local needs.

A continuing internal advisory body to provide advice to the Mental Health Care Committee on ongoing issues of co-ordination would be extremely useful. It would fulfill the function desired on the Metro level. This internal advisory body would be representative and would concentrate on co-ordination, while the Mental Health Care Committee would continue to bring selected expertise to bear on emerging issues. This advisory body would provide the necessary central structure to which the municipal co-ordinating groups would relate.

The internal advisory body to the Mental Health Care Committee on co-ordination issues would be similar to MTDHC's internal advisory body to the Acute Care Committee on emergency services, the Metro Toronto Emergency Services Committee.

RECOMMENDATION #1

a) That an ADVISORY GROUP ON THE CO-ORDINATION OF METROPOLITAN TORONTO MENTAL HEALTH SERVICES be established by the Metropolitan Toronto District Health Council as an internal advisory body to provide continuing advice to the Metropolitan Toronto District Health Council, and through it to the Ministry of Health, on the co-ordination of mental health services in Metropolitan Toronto. The objective is the achievement of a rational, co-ordinated mental health services system.

Organization

The Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services will be accountable to the Metropolitan Toronto District Health Council and will report regularly to Council through the Mental Health Care Committee.

Terms of Reference

1. To provide continuing advice on a regular basis to the Metropolitan Toronto District Health Council, through the Mental Health Care Committee, on the effectiveness of co-ordination mechanisms in Metropolitan Toronto.

2. To encourage and facilitate the development of local mental health services co-ordinating groups.

3. To encourage mental health service providers to collaborate to meet gaps in service delivery.

4. To encourage consultation among general hospital psychiatric departments, psychiatric hospitals, public health units, local co-ordinating groups and community agencies affected, to discuss the development or re-development of mental health programs prior to implementation.

5. To identify, and rank in order of importance, mental health needs Metro-wide.

6. To recommend plans for the future development of mental health services in Metro.

Nucleus Membership

i) one representative from each of the six municipal co-ordinating groups

ii) two representatives from the Metropolitan Toronto District Health Council's Mental Health Care Committee

iii) a representative of the University of Toronto Department of Psychiatry (representing the teaching hospitals)

iv) one representative from each of Queen Street Mental Health Centre and Whitby Psychiatric Hospital

The Chairperson shall be selected by the Mental Health Care Committee. The membership will be recommended by the Mental Health Care Committee to the Metropolitan Toronto District Health Council.

Meeting/Reporting Dates

The Advisory Group should begin meeting in July 1984, and should meet monthly. Progress reports from the Advisory Group will be a standing item on the agenda of the Mental Health Care Committee. The Mental Health Care Committee will evaluate the Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services not later than March 31, 1985.

Staff Requirements

In addition to providing administrative support to the Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services, staff support is vital in assisting the development of co-ordinating bodies in those municipalities that do not currently have such an agency, and in assisting the formalization of nascent co-ordinating bodies. Some of the developing co-ordinating bodies have very limited resources with which to carry on their activities. Staff support is required to assist the municipal co-ordinating bodies in planning their assessment of community mental health service needs, to assure the standardization of information across the various municipalities, and to provide a communication link among the municipal groups.

RECOMMENDATION #1

b) That funding for staff resources to the Advisory Group on Co-ordination of Metropolitan Toronto Mental Health Services be made available by the Ministry of Health, in order to provide administrative support to the Advisory Group and to promote the successful development of co-ordinating bodies in those municipalities that do not currently have a co-ordinating agency.

Estimated Costs

The staffing of the Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services will be similar to that of the MTDHC's Metropolitan Toronto Emergency Services Committee. This Committee provides continuing advice to the MTDHC on the co-ordination of planning and operation of emergency services in Metro Toronto. Using the Emergency Services Committee

as a guide, the budget of the Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services may be estimated at $30,000 annually, obtained through the mechanism of Ministry of Health District Health Program Special Project funding.

One of the most important activities carried out by the Mental Health Care Committee through its Community Mental Health Task Force is the annual ranking of new program submissions to the Community Mental Health Services Program of the Ontario Ministry of Health. Since the MTDHC accepted this role in 1982, its recommendations have been followed by the Ministry of Health, to the degree possible with the available resources. This function has become an important and widely recognized part of the MTDHC mandate in mental health care. What is lacking, however, is a mechanism whereby the MTDHC can determine local priorities within the District. Municipalities, for example, have at present no organized process of determining priorities in their locality, nor do they achieve any structured input into the deliberations of the Mental Health Care Committee's Community Mental Health Task Force. This aspect of the MTDHC's mandate could profitably be shared with local co-ordinating groups, and could act as a powerful incentive in encouraging and facilitating the emergence of such groups.

RECOMMENDATION #2

a) That each municipality within Metro Toronto be encouraged to establish a group with broad-based representation to function as a MUNICIPAL MENTAL HEALTH SERVICES CO-ORDINATING BODY, to encourage co-ordination at the local level and to assist the Mental Health Care Committee in the carrying out of its mandate.

Suggested Terms of Reference

1. To assess and prioritize mental health service needs in the municipality.
2. To stimulate the planning and development of a broad range of mental health services.
3. To assess the need for allocation and re-allocation of mental health services.

4. To co-ordinate efforts to address the need for new services and (re)allocation of existing services.

5. To review and prioritize program submissions to the Community Mental Health Services Program, Ministry of Health (to allow for local input and evaluation prior to submission to the District Health Council's Community Mental Health Services Task Force), in accordance with guidelines provided by the MTDHC.

6. To work jointly with other municipal co-ordination structures on mutual service needs due to a common geographic area and/or common interest.

7. To advise the MTDHC, through the Mental Health Care Committee, on planning for mental health services in the municipality.

Suggested Membership

Representatives from:

i) hospital psychiatric services

ii) community mental health services

iii) departments of public health

iv) mental health consumer groups

v) inter-agency groups

vi) local mental health co-ordination services (if any)

vii) social agencies

viii) municipal politics

ix) the Advisory Group on the Co-ordination of Metropolitan Toronto Mental Health Services

It is essential that the above representatives be leaders in their respective areas and be able to adequately represent services and issues in these areas.

Each co-ordinating group may choose to add a number of members at large, to enable a more broad-based representation, e.g. lay public, religious leaders, etc.

Figure 4 illustrates the organization of the proposed co-ordination model for Metropolitan Toronto.

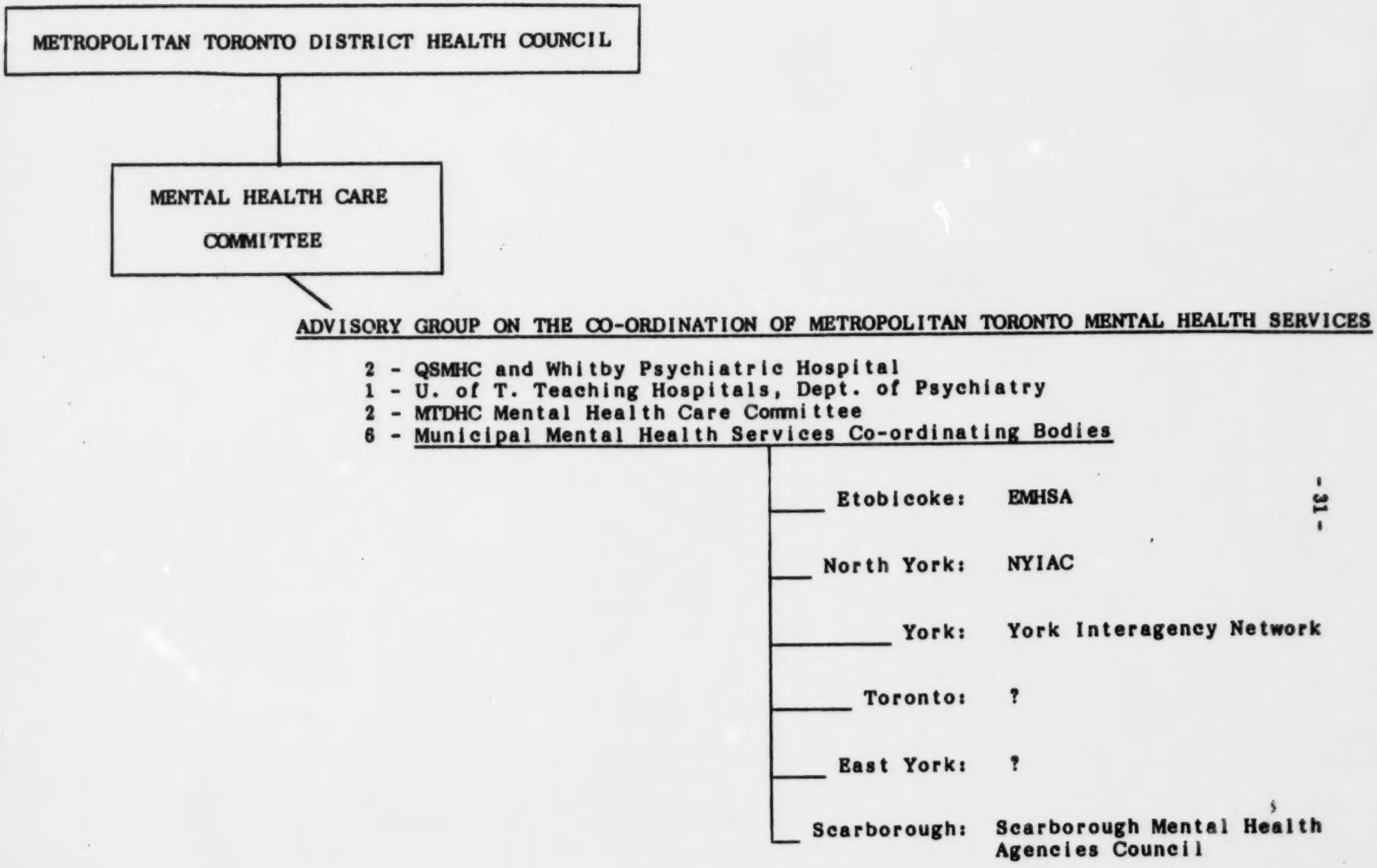
METROPOLITAN TORONTO DISTRICT HEALTH COUNCIL
MENTAL HEALTH CARE COMMITTEE
ADVISORY GROUP ON THE CO-ORDINATION OF METROPOLITAN TORONTO MENTAL HEALTH SERVICES
2 - QSMHC and Whitby Psychiatric Hospital
1 - U. of T. Teaching Hospitals, Dept. of Psychiatry
2 - MTDHC Mental Health Care Committee
6 - Municipal Mental Health Services Co-ordinating Bodies
Etobicoke: EMHSA
North York: NYIAC
York: York Interagency Network
Toronto: ?
East York: ?
Scarborough: Scarborough Mental Health Agencies Council

FIGURE 4: PROPOSED CO-ORDINATION MODEL FOR METROPOLITAN TORONTO MENTAL HEALTH SERVICES

RECOMMENDATION #2

b) That local municipalities presently without mental health co-ordinating bodies apply for funding to the Ministry of Health to establish and maintain municipal mental health services co-ordinating bodies.

Estimated Costs

The cost of implementing a Municipal Mental Health Services Co-ordinating Body may be estimated from the budgets of the two established mental health services co-ordinating bodies in Metro Toronto: the City of Etobicoke's Etobicoke Mental Health Services Agency (EMHSA), and the City of North York's Mental Health Sub-committee of the North York Inter-Agency Council (NYIAC).

EMHSA has a budget of $110,228 (1982-83) and NYIAC's Sub-committee on Mental Health has a budget of $126,811 (1982-83).

The City of Scarborough has submitted a proposal for funding a mental health services co-ordinating body to the Ministry of Health's Community Mental Health Services Program this year. A budget of $182,751 has been suggested for the recently organized "Scarborough Mental Health Agencies Council" (SMHAC). (This program was ranked highly by the MTDHC's Community Mental Health Task Force in its priority ranking of proposals submitted to the Ministry of Health, March 15, 1984.)

The co-ordination model recommended is a voluntary, evolutionary model. It recognizes the MTDHC's responsibility for co-ordination and proposes a means of carrying it out. Through this model the MTDHC is encouraging local co-ordinating groups to participate in its mandate to co-ordinate Metropolitan Toronto's mental health care services. *

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* The complex problems associated with planning local services in large metropolitan areas have been recognized in reports on other health services, and solutions have been proposed. The Mustard report, for example, recommended that "In large metropolitan areas it is important that the planning arrangements under District Health Councils be suitably modified and decentralized to meet the local needs of a complex metropolitan area."[15]

SECTION III

5. CRISIS INTERVENTION

Crisis intervention is a crucial component of a mental health services system. Indeed, it has been held that crisis intervention is a service that should be given first priority in any public health system.

Crisis intervention services have become increasingly important with the advent of deinstitutionalization, since many individuals with severe and chronic mental disorders who formerly would have been held within psychiatric institutions are now living in the community. Because these individuals are so vulnerable to stress, and because their psychiatric problems tend to recur, crises may be expected periodically and assistance required, often on an emergency basis.

The mental health reports reviewed in Section I indicated that crisis intervention was clearly an area of need. The Heseltine final report for the Ministry of Health, issued in December, 1983, identifies two groups of patients who are having difficulty obtaining the services they require - the primary group being those who are in crisis. [16] The report states that resolving the issue of the availability of crisis services should be a major priority for the Ministry. The recently released report of the Mayor's Action Task Force on Discharged Psychiatric Patients in Toronto (February, 1984) also identifies the lack of crisis intervention resources as a gap in services and recommends steps for improving the situation. [17]

The services provided for managing a crisis - by definition a turning point - is a decisive factor in determining the movement of an individual within the mental health services system.

The type of crisis intervention resources available can mean the difference between a person remaining in the community or going into hospital, or, in the absence of services, possibly going to jail. [18]

"Crisis intervention" is a widely-used term, commonly employed to describe a range of different actions. In the field of mental health, it is frequently used to mean any of a variety of responses provided to a person in crisis. "Crisis" here might fit the definition suggested by Bartolucci and Drayer [19] as being "acute

distress". These responses can mean counselling, medication, removal to another physical setting in the community, or hospitalization.

Crisis also appears to carry with it the connotation of violence and unmanageability when applied to the mentally ill. In this situation, the crisis response may be calling the police.

There appears, however, to be a commonly shared understanding as to two characteristics of crisis: a sense of urgency for some action to be taken, and a sense of upset in the situation of others as well as in the situation of the individual. A definition that incorporates these characteristics is the following:

> Crisis: A serious interruption in the normal way of life of an individual or group, resulting from the occurrence of an unexpected situation for which the individual or group is not prepared, and which raises problems for which customary responses are not adequate. A crisis requires the development of new modes of thought and action.[20]

In designing the Mental Health Care Committee's study of crisis intervention, both the popular understanding and usages of the term "crisis intervention" and a formal meaning - to describe a specific treatment approach (outlined in 5.1) - had to be taken into consideration in order to adequately examine the issues involved.

Questions to be answered by a study in this area included:

- What choices are available to a person who feels himself to be in a crisis situation?
- What choices are available to a concerned other, e.g. relative, landlord, who feels someone else is in a crisis situation?
- How do the current crisis intervention services function?
- How accessible are these services?
- What type of individuals are the present services not able to cope with effectively?
- What are the "felt needs" in this area?
- What suggestions for improvement of existing services are available from community "crisis handlers" such as the police?

5.1 Crisis Intervention Theory

The crisis approach to therapeutic intervention has been developed only within the last few decades and is based on a broad range of theories of human behaviour, including those of Freud, Hartmann, Rado, Erickson, Lindemann, and Caplan.[21] Its current acceptance as a recognized form of treatment cannot be directly related to any single theory of behaviour; all have contributed to some degree.

Caplan defines crisis as occurring "when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solutions are made".[22] In essence, the individual is viewed as living in a state of emotional equilibrium, with his goal always to return to or maintain that state. When customary problem-solving techniques or coping mechanisms are inadequate to meet the daily problems of living, the balance or equilibrium is upset. The individual must either solve the problem or adapt to nonsolution. In either case, a new state of equilibrium will develop, sometimes better and sometimes worse insofar as positive mental health is concerned.

According to Caplan, there are four developmental phases in a crisis:

1. There is an initial rise in tension as habitual problem-solving techniques are tried.
2. There is a lack of success in coping as the stimulus continues and more discomfort is felt.
3. A further increase in tension acts as a powerful internal stimulus and mobilizes internal and external resources. In this stage emergency problem-solving mechanisms are tried. The problem may be redefined or there may be resignation and the giving up of certain aspects of the goal as unattainable.
4. If the problem continues and can neither be solved or avoided, tension increases and a major disorganization occurs.

When a stressful event occurs, certain "balancing factors" can effect a return to equilibrium; these are: perception of the event, available situational supports (e.g. family, friends), and coping mechanisms. The "paradigm of intervention" is shown in Figure 5. [23]

Within crisis theory, coping is defined in a specific way. It includes the usual intrapsychic defense mechanisms such as denial, repression, projection, and so forth, as well as customary interpersonal behaviour such as dependence on others or interdependence with others. Further, it encompasses maladaptive behaviours such as taking drugs, and it includes symptom formation. Coping, as used here, can be either adaptive or maladaptive. In either case, it maintains or re-establishes a state of equilibrium.

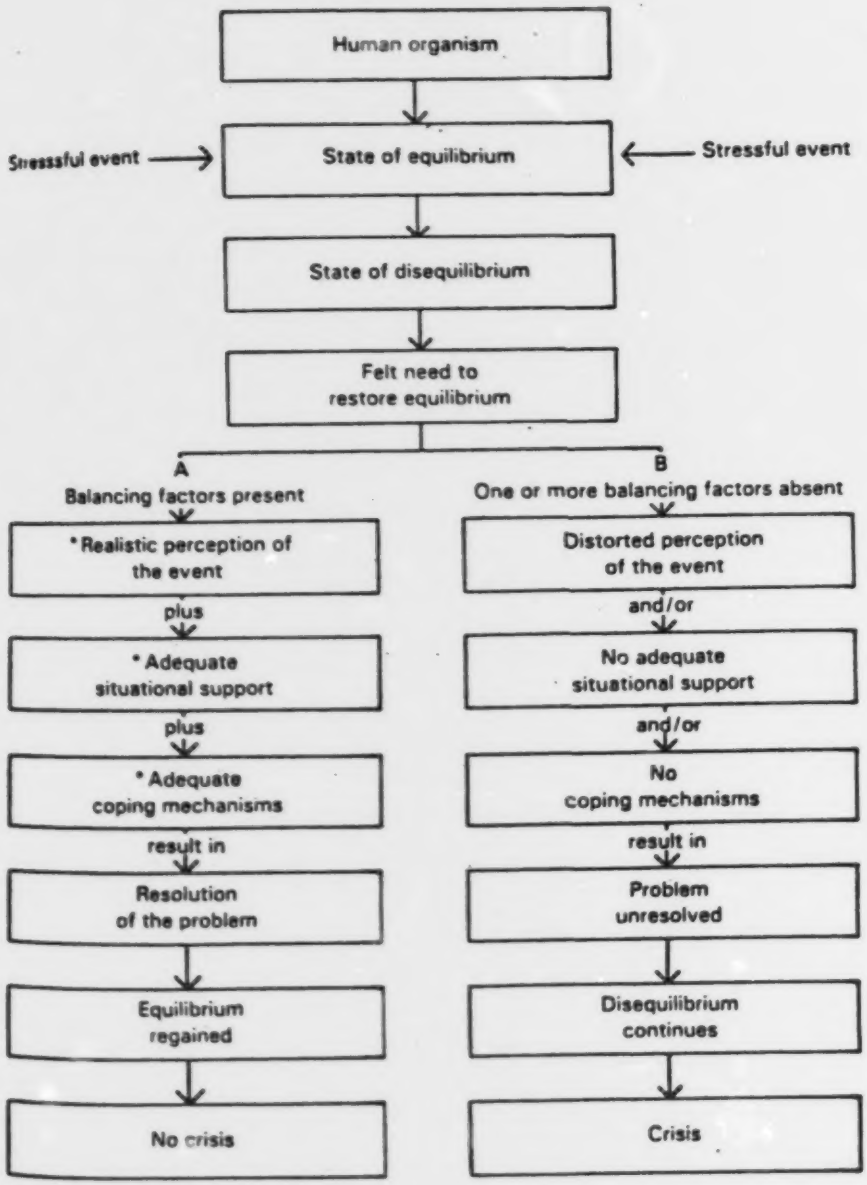
When coping is no longer effective, a state of crisis occurs, characterized by disorganization and upset. There are painful feelings of anxiety, depression, hopelessness, and helplessness. Under severe stress, or in predisposed individuals, suicidal or homicidal impulses or behaviour may occur at the peak of the crisis state.

Crisis intervention therapy may be briefly described as proceeding in the following steps:

1. Assessment of the precipitating event and the resulting crisis. The therapist may have to judge whether the individual presents a high suicidal or homicidal risk. If the patient is thought to be a danger to himself or others, referral is made to a psychiatrist for consideration of hospitalization. If hospitalization is not deemed necessary, the intervention proceeds.

2. Planning of therapeutic intervention.
   This is designed to restore the person to at least his pre-crisis level of equilibrium. Information is sought to determine what strengths the individual has, what coping mechanisms have been used successfully in the past, and what people in his life might be used as supports for him.

FIGURE 5: PARADIGM OF INTERVENTION: THE EFFECT OF BALANCING FACTORS IN A STRESSFUL EVENT



*Balancing factors.

3. The intervention.

The nature of intervention techniques is highly dependent on the pre-existing skills, creativity, and flexibility of the therapist.

Table 1 sets out a profile of the major differences between crisis intervention methodology, brief psychotherapy, and psychoanalysis. [24]

Table 1 Major Differences Between Crisis Intervention, Brief Psychotherapy, and Psychoanalysis

	Crisis Intervention	Brief Psychotherapy	Psychoanalysis
Goals of Therapeutic Intervention	Resolution of immediate crisis	Removal of specific symptoms	Restructuring the personality
Focus of Treatment	1. Genetic * present	1. Genetic past as it relates to present situation	1. Genetic past
	2. Restoration to level of functioning prior to crisis	2. Repression of unconscious and restraining of drives	2. Freeing the unconscious
Usual Activity of therapist	1. Suppressive 2. Active participant 3. Direct	1. Supressive 2. Participant observer 3. Indirect	1. Exploratory 2. Passive observer 3. Nondirective
Indications	Sudden loss of ability to cope with a life situation	Acutely disruptive emotional pain and severely disruptive	Neurotic personality patterns circumstances
Average length of treatment	From one to six sessions	From one to twenty sessions	Indefinite

* "Genetic" is used here in the sense of the life history and experience of the individual.

Medication may be used in conjunction with crisis intervention and brief psychotherapy, if necessary, but is not used in psychoanalysis.

Various factors have stimulated a growing interest in the crisis intervention approach. Three major influences have been the following:

1. It has been shown to be effective in preventing hospitalization. [25]
2. It is effective with chronic psychiatric patients as well as with non-chronic psychiatric patients.
3. It can be practised by a wide variety of mental health workers, not only by psychiatrists.

5.2 Study Approach

The following methods were utilized to carry out the study of crisis intervention in Metropolitan Toronto:

1. Review of the literature.
2. Analysis of information collected via the "Inventory of Adult Mental Health Services" questionnaire.
3. Interviews at all 19 acute care general hospitals.
4. Interviews with selected community mental health services.
5. Interviews at all 6 municipal departments of public health.
6. Interviews at both provincial psychiatric hospitals.
7. Interviews at the Clarke Institute of Psychiatry.
8. Interviews with the Metropolitan Toronto Police Force.
9. Interviews with Ambulance Services personnel.
10. Observation at the public information-gathering meetings of the Mayor's Action Task Force on Discharged Psychiatric Patients, which included a "speak out" meeting for discharged psychiatric patients.
11. An interview with the Chief Judge of the Provincial Court (Criminal Division).
12. Observation in the Emergency Department of an acute care general hospital.

The Mental Health Care Committee also heard presentations regarding crisis intervention from the Co-ordinator of the Supportive Housing Coalition, the

Director of Emergency Services at an acute care general hospital, and the Chairman of the University of Toronto Department of Psychiatry Executive Sub-committee on Emergency Psychiatry.

Additional information regarding the study approach is contained in Appendix IX.

5.3 Findings

The following services are available to the residents of Metropolitan Toronto when a mental illness related crisis arises.

5.3.1 Distress Lines

There are 6 distress lines serving Metropolitan Toronto:

Alternatives
Distress Centre I
Distress Centre II
Salvation Army Emergency Counselling and Suicide Prevention
Scarborough Distress Centre
Telecare Etobicoke

These services, largely staffed by trained volunteers, are available 24 hours a day. They provide sympathetic listening, befriending, advice and referral. The Distress Centres arrange for ambulance dispatch in the case of a suicidal emergency. The Salvation Army arranges follow-up home visits to its callers upon request.

The distress line service is easily accessible - as near as the telephone - and the distress line numbers are prominently displayed in the telephone book. Distress Centres I and II advise they can provide services to callers in a variety of languages.

In 1982 the distress lines handled 85,001 calls. Approximately 10% to 25% of the calls involved emotional, mental or suicidal problems.

5.3.2 Native Community Crisis Team

The Native Community Crisis Team officially began operating in November 1982 as a mental health service specially designed for Canadian Indians and Metis. The Team is made up of Native Counsellors and one non-Native member: the consultant psychiatrist. The Team is located in a house in downtown Toronto, close to the Native community. During its first six months of operation, visits at home accounted for about one-third of the Team's 203 sessions with clients.

The Native Community Crisis Team provides the following services, Monday to Saturday, 9 a.m. to 5 p.m.:

- Crisis intervention
- Psychiatric Emergency intervention and short-term counselling
- Assessment of problem situations
- Information and referral

In the initial six months of operation 56.7% of the 73 cases seen were classified as immediate psychosocial crises. 21.6% of the clients had a history of suicide attempts. For 13.3% of the clients, alcohol or drug abuse was the primary problem. Severe pathology was the classification of 10% of the clients.

Assistance in psychiatric emergency cases is provided through the back-up services of the Crisis Intervention Unit of the Toronto East General Hospital. The Native Community Crisis Team is an outreach program of the Crisis Intervention Unit of the Department of Psychiatry, Toronto East General Hospital. The program has a separate budget: $86,000 for its first twelve months.

Staffing of the Team is as follows:

2 full-time Native counsellors
1 part-time Native psychologist
1 part-time Native liaison officer
1 consulting psychiatrist

This program is unique in Metropolitan Toronto in many ways, not the least of which is that the importance of liaison and co-ordination activities have been recognized and acknowledged by the hiring of a staff member whose main function is liaison with other agencies.

5.3.3 General Hospital Emergency Department Services

In recent years there has been a well-documented increase in the number of patients coming to emergency departments of urban hospitals throughout North America; this has meant as well an increase in the number of psychiatric referrals to emergency departments. Table I in Appendix X indicates the number of visits to emergency departments of acute care general hospitals in Metropolitan Toronto. In detailed studies of emergency departments, psychiatric patients as a percentage of the total emergency department caseload have been found to make up from 11% to 29.6%. [26] Studies examining patients actually triaged to psychiatric services, however, report lower percentages, in the range of 3% to 4%.[27] This is consistent with findings in Metropolitan Toronto: a 1982 study at Mount Sinai Hospital found approximately 10% of their emergency department cases were psychiatric cases; [28] information from Toronto General Hospital indicates 3% of emergency patients are referred for a psychiatric consultation.

Using the conservative estimate of 10% of emergency department patients having "psychiatric" problems rather than physical problems, or in addition to physical problems, results in the following:

Estimated Number of "Psychiatric" Emergency Visits to Emergency Departments in Metropolitan Toronto Hospitals

Toronto East General	6,970
Etobicoke	7,258
Queensway General	5,997
North York Branson	4,831
North York General	11,000
Sunnybrook Medical Centre	3,577
York Finch General	6,337
Scarborough Centenary	6,223
Scarborough General	8,000
Doctors	1,849
Mount Sinai	4,891

St. Joseph's Health Centre	4,200
St. Michael's	3,600
Toronto General	3,600
Toronto Western	3,689
The Wellesley	4,522
Women's College	1,661
Humber Memorial	4,885
Northwestern General	5,298

The figures given in the literature for the proportion of "psychotics" in general hospital Emergency Services psychiatric populations vary from 20% to 31%. [29] The percentage of neurotics reported in emergency populations ranges from 15.3% to 40%. [30] The representation of alcoholics in emergency populations ranges from 12.5% to 36.7%. [31] It is difficult to obtain from the literature a consistent figure for the patients with a primary diagnosis of personality disorder.

From the literature reviewed, it appears the "psychiatric" group differs from the general emergency group in the following ways:

- there is a higher proportion of females
- there are more single, separated, or divorced people
- there are more people in their 30's and 40's (with the exception of middle-aged male alcoholics) and fewer older people
- there are more transients
- there are more referrals by the police
- there are more admissions to hospital

The figures for hospital admissions of emergency department psychiatric patients vary from 16% to 43%. [32]

An extensive study that examined the impact of deinstitutionalization on the general hospital psychiatric emergency ward, found that 20% of the patients seen had a history of previous psychiatric hospitalization. [33]

The point has been emphasized that merely counting the number of psychiatric emergency patients does not give an adequate impression of the proportionate work load, since most patients who are identified as having a psychiatric problem must occupy at least half-an-hour of staff time and sometimes an hour or more:

there is no psychiatric equivalent of the cut finger. This creates a severe problem in the emergency room setting where rapid assessment is given a high premium and rapid dispositions are demanded. An emergency department physician interviewed advised that an out-of-control psychiatric emergency patient causes as much a disruption in the emergency department as a trauma case.

All patients presenting at an emergency department of a general hospital are initially attended by a physician; consultation with a psychiatric resident (if a teaching hospital) or staff psychiatrist is at the discretion of the physician. It appears that two conditions are required for a physician to request a psychiatric consultation: uncertainty about the nature of a patient's behaviour, and responsibility for doing something about the behaviour.

A particularly difficult problem for the emergency department staff is the involuntary patient, since the staff are used to dealing with persons who voluntarily seek help or are in no condition to refuse it. A physician who must attend a patient who may be a danger to himself or others, such as one who has attempted suicide or threatened violence, is faced with the decision of whether or not to certify the patient and admit him to hospital involuntarily. Under Section 14 of the Mental Health Act the attending physician has the responsibility to admit a person as an involuntary patient if the physician is of the opinion that (1) the person has a mental disorder that likely will result in serious harm to himself or others unless the person remains in the custody of a psychiatric facility, and (2) is unsuitable for informal admission. Section 14 also specifically directs that the attending physician shall not complete a certificate of involuntary admission unless he is of the opinion that both the above conditions are satisfied. (See Appendix XI for Section 14 of the Mental Health Act). If the physician does commit the patient, the physician may be vulnerable to litigation later. If he does not commit the potentially dangerous psychiatric patient and the patient goes on to fulfill that potential, even greater problems arise.

A brief description that conveys the complex issue posed by the psychiatric patient in the emergency department follows:

"The emergency room therapist is confronted with patients of all diagnostic categories suffering from the entire spectrum of acute symptoms. Typically the patients have long-standing and difficult-to-untangle psycho-social problems that may be complicated by underlying medical disorders. Moreover, many patients come to the emergency room involuntarily under physical coercion by police or family and are not motivated for treatment; often they are belligerent. Suitable dispositions may be impossible to arrange because of difficult relations with neighbouring facilities, long waiting lists to out-patient clinics, or the unavailability of in-patient beds". [34]

With regard to physical resources available for psychiatric emergencies at Metropolitan Toronto general hospitals, a survey indicates a minority of hospitals have holding or observation facilities for psychiatric patients. Only three of the nineteen acute care general hospitals in Metro have any "secure" beds, making the hospitalization of a patient exhibiting violent behaviour a very great problem. The general hospitals have traditionally looked to the provincial psychiatric hospital to accept the assaultive patient. This situation has recently changed however, due not only to a lack of available beds at Queen Street Mental Health Centre, but also to Queen Street's position that it is not better equipped to cope with assaultive patients, and that the general hospitals should take responsibility for treating these patients in their own facilities.

A minority of the general hospitals have crisis beds for brief hospitalization. [35] The number of in-patient beds available in each hospital, including brief hospitalization (time-limited) * beds, is presented in Table 2.

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* From 12 - 72 hours

Table 2

	Crisis/Brief Hospital-ization Beds	Secure * Beds	Total In-Patient Psychiatric Approved Beds
Toronto East General	10	-	40
Etobicoke General	1	-	40
Queensway	-	-	20
N.Y. Branson	3	3	28
N.Y. General	-	-	73
Sunnybrook	-	-	50
York-Finch	-	-	17
Scarborough Centenary	-	-	44
Scarborough General	-	-	25
Doctors	-	-	9
Mount Sinai	1	2	26
St. Joseph's	-	-	25
St. Michael's	-	-	34
Toronto General	6	6	42
Toronto Western	4	-	28
Wellesley	2	-	29
Women's College	-	-	35
Humber Memorial	6	-	50
Northwestern	2	-	30
	35	11	645

* Defined as beds in a "special secure/locked area" [36]

Additional resources available, such as the presence of an out-patient department or day care services are shown in Table 3.

Table 3

	Out-Patient Department	Day Treatment Service
Toronto East General	X	X
Etobicoke General	X	X
Queensway	X	not available
N.Y. Branson	X	X
N.Y. General	X	X
Sunnybrook	X	X
York-Finch	X	not available
Scarborough Centenary	X	X
Scarborough General	X	X
Doctors	not available	not available
Mount Sinai	X	X
St. Joseph's	X	X
St. Michael's	X	X
Toronto General	X	not available
Toronto Western	X	X
Wellesley	X	not available
Women's College	X	X
Humber Memorial	X	X
Northwestern	X	X

The increased demand for psychiatric emergency services plus high occupancy rates have resulted in a time-consuming problem for the emergency department physician in search of an available psychiatric in-patient bed. Literally hours are reported to be spent on the telephone attempting to locate and arrange admission to another hospital's in-patient unit. The occupancy rates of the general hospital psychiatric units are presented in Table 4. (Appendix XII presents further statistical data on psychiatric facility utilization.)

Table 4: Psychiatric Facility Utilization 1982-83

Facility	Approved Beds	% Average Occupancy	Average Length of Stay (Days)
Toronto East General	40	88.5	12.4
Etobicoke General	40	97.0	19.6
Queensway	20	92.5	15.3
N.Y. Branson	28	70.7	12.2
N.Y. General	73	91.8	22.0
Sunnybrook	50	90.6	46.0
York-Finch	17	88.2	8.8
Scarborough Centenary	44	95.0	13.7
Scarborough General	25	91.6	8.2
Doctors Hospital	9	100.0	**
Mount Sinai	26	86.2	63.9
St. Joseph's	25	98.4	14.6
St. Michael's	34	89.1	32.8
Toronto General	42	96.0	19.8
Toronto Western	28	78.2	31.0
Wellesley	29	93.1	17.0
Women's College	35	74.3	29.1
Humber Memorial	50	89.2	21.9
Northwestern	30	85.7	15.8
Clarke Institute	139	88.5	38.2
Queen Street	618	95.1	65.4
Whitby P.H.	415	90.6	109.1

** As of March 31, 1983, no detailed statistics were available.

Source: Ministry of Health, Data Development and Evaluation Branch

In response to this problem, the lack of available psychiatric in-patient beds, the University of Toronto Department of Psychiatry has developed an Emergency Bed Registry and has established sub-committees to examine the utilization of emergency services and the utilization of clinical services.

The increased demand for psychiatric emergency services can also lead to modifications in the existing emergency service delivery system. Many of the newly developed psychiatric emergency services, which in the past have provided evaluation and disposition, have developed additional flexibility by adding both brief treatment (crisis intervention) and brief hospitalization options. The aim of a crisis intervention service is to treat patients without removing them from the community. Treatment is based on the principles of prompt intervention, identification of precipitating stresses, and formulation of treatment goals commensurate with short-term crisis therapy. [37] Expanded crisis services meet a wider variety of patients' needs.

Extended emergency contact beyond the initial crisis period has been found useful to the patient in the identification of problems and in the continuation of care for those patients who use the emergency department as their main resource. [38] As well, the option of brief hospitalization allows the patient to be closely observed while treatment plans are formulated, and permits the effects of medication to be observed and adjustments made if necessary. A brief hospitalization unit also allows the patient to be temporarily removed from a stressful living situation.

Supervised and supportive temporary hostel accommodation can also provide an alternative to hospital in-patient beds for those psychiatric patients in crisis coming to the hospital emergency who primarily wish or require removal from a stressful living situation. (This includes those patients who are homeless.)

Many descriptions of recommended crisis intervention services for psychiatric emergencies in the emergency department have characteristics in common: [39]

1. A multi-disciplinary team (a "medico-psycho-social" team)
2. Round-the-clock, seven-day-a-week coverage
3. Access to a quiet and comfortable interview room
4. Access to nearby holding beds
5. Physical resources for temporary seclusion, and also restraint
6. Access to brief hospitalization beds

7. A team work schedule that allows for:
   i) seeing follow-up visits in extended emergency contacts
   ii) maintaining personal contacts with community mental health agencies (including regular on-site visits)

The implementation of such a crisis intervention service in the emergency department of the general hospital could intercept the flow of patients into in-patient beds, and decrease the demand on in-patient beds.

5.3.4 General Hospital Specialized Crisis Services

All general acute care hospitals in Metropolitan Toronto have the capacity to respond to patients in crisis who present at their facilities. At some hospitals, such as Scarborough Centenary, access to mental health services is facilitated by allowing patients in crisis to come (during regular office hours) directly to the psychiatric unit, rather than presenting at the Emergency Room. Few general hospitals, however, have developed a service whose primary function is to address this need for crisis services.

5.3.4.1 Crisis Intervention Programme - Etobicoke General Hospital

The Crisis Intervention Programme is located within the hospital and all referrals to it come through the Emergency Department, via a physician's order. Services provided by the crisis intervention team are:

- Assessment
- Crisis counselling
- Follow-up
- Referral

The hours of service are: Monday to Friday, noon - 11:30 p.m.
Saturday & Sunday, 3:00 p.m. - 10:00 p.m.

There is a very wide variety of primary presenting problems: in 1982 of 859 cases, 17.3% presented with anxiety or depression; 14.9% were drug or alcohol abuse problems; 10.2% were classified as marital/lifestyle problems; and 3.8% were

suicide attempts. Family problems, inlcuding spouse assault and child abuse accounted for 23.4% of the primary presenting problems.

30% of the clients had previously been in-patients at Etobicoke General Hospital. 48.1% of the cases were referred to other agencies, and 25.7% of the cases were referred to the hospital's psychiatrists.

The Programme has its own budget: $108,526 (1981) and has the following staff:

1 full-time psychiatrist (director)
3 full-time social workers
2 part-time volunteers contribute 1 hour per month

5.3.4.2 Crisis Intervention Unit - Toronto East General & Orthopaedic Hospital

The Crisis Intervention Unit is located within the hospital and provides three main services:

- o Consultation in the Emergency Room
- o Short-stay in-patient treatment
- o Crisis out-patient therapy

A. Consultation in the Emergency Room

The main point of entry into the system is through the Emergency Department; all referrals are first seen by a physician. During a 9-month period (1980) 1,365 patient contacts were made in the Emergency Room service, an average of 5 per day. Of these total contacts, 37% had attempted suicide or had suicidal ideation. 29% presented with a major problem of anxiety or depression, 11% with alcohol or drug abuse, and 10% with psychosis.

55% of all patients seen in the Emergency Room by Crisis Intervention Unit staff had some previous psychiatric treatment. 79% of all patient contacts received some form of follow-up referral. Of this group, 74% were kept within the Crisis Intervention Unit system. 25% of the toal patient contacts were referred to the Crisis Intervention Unit out-patient service. 22% were admitted to the In-patient service.

The hours of operation are:	Monday to Thursday,	9:00 a.m. - 1:00 a.m.
	Friday & Saturday,	24 hours
	Sunday,	9:00 a.m. - 1:00 a.m.

The staff consists of:

- 2 full-time psychologists
- 2 full-time social workers
- 1 full-time equivalent psychiatrist
- 3 full-time equivalent psychometrists
- 2 full-time equivalent mental health workers

Approximately 100 volunteers contribute about 385 hours per month.

B. In-patient Crisis Intervention Unit

The In-patient Crisis Intervention Unit can accommodate 10 patients per day. The intended maximum length of stay is 72 hours. 50% of patients are referred from sources within the hospital, and during a 9 month study period (1980) 540 patients were admitted.

60% of the patients admitted had had at least one previous hospitalization (36% had two or more). 42% of the patients had either suicide attempt or suicidal ideation/threat as the major presenting problem.

The average length of stay on the unit was 2.9 days; 64% of the patients were able to be discharged from the unit within 3 days. 25% of the patients admitted had to be transferred to a longer-term unit. 100% of the patients discharged were referred to community resources for follow-up.

The staff of the In-patient Crisis Intervention Unit is:

- 1 part-time psychiatrist
- 1 part-time physician
- 1 full-time intern
- 5 registered nurses
- 1 full-time, 1 part-time nursing assistant
- 1 part-time psychologist

5.3.4.3 Self-Harm Assessment, Research and Education (S.H.A.R.E.) - Toronto General Hospital

The S.H.A.R.E. program has two components: the out-patient service and the in-patient unit. Both services specialize in treating self-harm patients.

A. S.H.A.R.E. - Out-patient Service

This program offers:

- o Crisis Intervention
- o Short-term psychotherapy (less than 6 months)
- o Long-term psychotherapy
- o Assessment
- o Counselling

Most of the patients are those discharged from the S.H.A.R.E. In-patient Unit. 80% of referrals come from within the hospital. Direct referrals can be made for assessment of self-harm/risk behaviour or psychosocial crisis.

The service can accommodate 30 patients per month (maximum). In a one-year period, approximately 100 patients were seen, with a total of 550 patient contacts.

The unit provides care for the following patients:

1. All patients presenting to Emergency following a self-harm incident.
2. Patients seen in Emergency who require hospitalization for assessment of suicidal risk.
3. Patients seen in Emergency who are not necessarily suicidal, but can benefit from a brief admission to resolve a current psychosocial crisis.
4. Patients from other Toronto General in-patient or out-patient services, or from outside the hospital who require in-patient assessment of self-harm risk or behaviour.

The hours of service are: Monday to Friday, 9:00 a.m. - 5:00 p.m.

The program is staffed by one full-time and one part-time social worker; a psychiatrist, psychiatric resident, and psychologist play a minor role in its operation.

B. S.H.A.R.E. - In-patient Unit

There are 6 beds on the In-patient S.H.A.R.E. Unit for brief, crisis oriented admissions. Most patients are admitted from the Emergency Department.

In a 5 month study period (1983) 115 patients were admitted; approximately 1/3 were re-admissions. The usual length of stay is from 3 days to 1 week, and less than 10% are referred for long-term in-patient care.

The most frequent diagnosis is personality disorder, and many patients have a history of previous admissions to in-patient facilities.

The S.H.A.R.E. in-patient team is multidisciplinary.

5.3.5 Psychiatric Hospital Emergency Services

There are three psychiatric hospitals serving the citizens of Metropolitan Toronto: the Clarke Institute of Psychiatry, Queen Street Mental Health Centre, and Whitby Psychiatric Hospital.

The Clarke Institute is a psychiatric research institute, while Queen Street Mental Health Centre and Whitby Psychiatric Hospital are both provincial psychiatric hospitals.

The Clarke Institute of Psychiatry

The Clarke Institute of Psychiatry was established to function as a hospital with facilities for psychiatric research, education, diagnosis and treatment.

The "Primary Care Service" of the Clarke Institute is a comprehensive crisis service. It provides emergency service and has a crisis oriented brief stay ward of 20 beds to back up this service. Crisis Intervention techniques, intensive brief psychotherapy, and family crisis therapy are employed in a multidisciplinary team approach. Rapid neuroleptization techniques are applied in the management of acutely disturbed psychiatric patients.

The emergency service operates 24 hours a day; an emergency phone line is also provided.

In one year there were 5,000 emergency visits to the Emergency Services; half were self or family referrals. [40] In a study of emergency patients in 1982, approximately 60% of those patients presenting at the Emergency Service were not considered true "emergencies". The most frequent presenting complaint was anxiety or depression. For those patients admitted to the brief stay ward, the median length of stay was 4 days.

Queen Street Mental Health Centre

One of ten Ontario provincial psychiatric hospitals, Queen Street Mental Health Centre (QSMHC) has a centralized admitting department staffed by a psychiatrist and a multidisciplinary assessment-admitting team (8:00 a.m. - 4:30 p.m.). There are two 14-bed crisis units available for extended observation and crisis care, as well as a forensic and special observation unit (potentially a 16-bed unit) for those patients who present a high suicidal, homicidal, or elopement risk.

During evening hours (4:30 p.m. - 11:00 p.m.) and at night (11:00 p.m. - 8:00 a.m.) psychiatric coverage is provided by a psychiatric resident.

In one year there were 6,428 emergency visits to Queen Street.[41] Approximately 60% were self referrals. 3,012 patients were assessed and not admitted. For those patients admitted to the crisis units, the average length of stay is from 3 to 7 days.

QSMHC also provides crisis services through four satellite clinics located around the city of Toronto: Archway, Central Link, Community Inn, and Spectrum. The satellite clinics deliver a variety of services, including crisis intervention and home visits for the purpose of assessment. A psychiatrist or psychiatric resident is available for some portion of the time at each of the clinics. The psychiatrists do home assessments with clinic staff at the request of the clinic therapists, public health nurses, general practitioners, or the police. These home crisis assessments are time-consuming, sometimes taking up to 6 hours before final arrangements are completed, if a patient requires hospitalization. The amount of time spent doing crisis assessments at home means time spent away from delivering other scheduled clinic services.

A major problem for the clinics and the patients involved is that of a QSMHC team trying to arrange the admission of a patient into a general hospital. As a result, the crisis service activities of the clinics run the risk of acting as a funnel into QSMHC for persons who were not previous QSMHC patients.

Whitby Psychiatric Hospital

Whitby Psychiatric Hospital, a provincial psychiatric hospital, provides emergency services on a 24 hour basis. There are 105 "General Adult Admissions" beds serving Metro Toronto patients; there is no crisis unit for adult patients. During the day, psychiatric coverage is provided by the duty doctor - either a physician or psychiatrist. "Walk-ins" during the day are always seen by a psychiatrist. At night (4:30 p.m. - 8:15 a.m.), a duty doctor provides psychiatric coverage; again, this may be a physician or psychiatrist.

Because of Whitby Psychiatric Hospital's distance from Toronto - 50 kilometres, the majority of Metropolitan Toronto patients using its services are referrals from general hospitals rather than self referrals. Because of the distance as well,

neither Whitby's day hospital program nor its out-patient services are able to serve as an alternative to hospitalization for Metro Toronto residents.

5.3.6 Department of Public Health

There are 6 municipal departments of public health within Metropolitan Toronto, and they are all called upon to provide service in cases involving psychiatric crises. The public health units are an established presence in the community, known to agencies and the public alike, and are well-publicized as providing both mental health care and home visiting services. Frequently, the public health department is called in on cases involving a non-compliant mentally ill person, or a person who appears to be mentally ill but has not previously been diagnosed as such. Public Health nurses are often able to achieve entry into a person's home for purposes of assessment because the nurses are seen as help-providers and are trusted. When a nurse decides the client is in need of psychiatric assessment and is unable to persuade the client to seek this assistance willingly, a problem arises. Family doctors are reportedly reluctant to make home visits to issue an application for psychiatric assessment (Form 1). This application is sufficient authority for any person (often the police) to take the designated individual, in custody, to a psychiatric facility for up to five days. (See Appendix XIII).

Some Medical Officers of Health also are hesitant to issue this application for assessment if they are unfamiliar with the individual and are seeing him for the first time. One Medical Officer of Health expressed the opinion that he did not want to resurrect the image of being "the man in the white coat coming to take you away".

The mental health crisis situation is the most time-consuming mental health activity of the public health nurse. Even with a compliant client willing to be accompanied to the general hospital for emergency assessment, often hours are spent on the case.

The public health department is not always in a position to respond to requests for crisis assistance since the departments operate from 8:30 to 4:30, Mondays to Fridays. As well, the staff is involved in a wide variety of health services to the community, and is not always readily available.

5.3.7 The Police

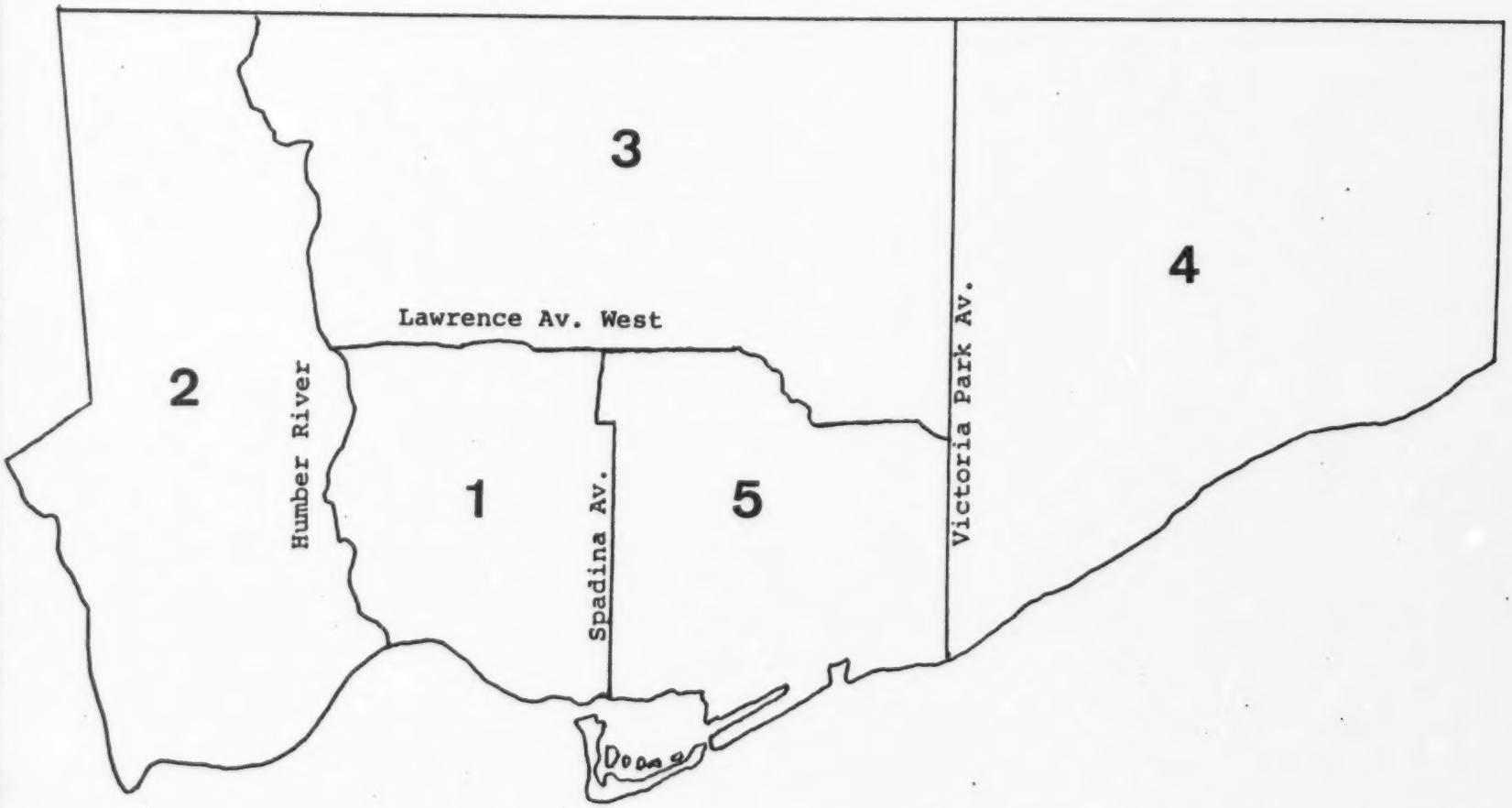
The police play a very important part in the delivery of crisis intervention services. Like the hospital emergency department, the police are available 24 hours a day, 7 days a week, and are easily accessible. In addition, they are able to make community visits in the home and elsewhere.

The role of the police is important both in terms of the authority they have under the Mental Health Act, and in terms of the numbers of apparently mentally ill persons they deal with. Under Section 11 of the Mental Health Act, a police officer has the authority to apprehend a person "apparently suffering from mental disorder" and appearing to pose a threat to himself or others, and convey the person, in custody, to a facility for psychiatric assessment. (See Appendix XIV for Section 11 of the Mental Health Act.) At some psychiatric facilities a significant proportion of admissions are police referrals. For example, at Queen Street Mental Health Centre police referrals have made up approximately 20% of total admissions over the last several years. In 1981-82, police referrals admitted to Queen Street numbered 747; this made the police the third most frequent source of admissions.[42] There were, of course, additional persons brought to the hospital by the police for psychiatric assessment but not admitted.

Police involvement with the apparently mentally ill is usually in response to a request for their intervention, rather than a result of their own initiative. In approximately 60% of cases studied, it was found there were no charges that police could have laid as an alternative to proceeding under the Mental Health Act.[43]

In order to determine the types of crisis intervention situations involving the mentally disordered encountered by police officers in the various areas of Metropolitan Toronto, interviews were held with officers from each of the five police districts of Metro.

The most frequent police occurrences concerning mentally disordered persons appear to take place in police districts 1 and 5, which include the downtown area of the City of Toronto. (See the map of police districts on the following page.)



METROPOLITAN TORONTO POLICE DISTRICTS

This supports the findings of a previous study of the Metropolitan Toronto Police Force and their involvement with the mentally ill. [44] That study notes that police recorded admissions to psychiatric facilities by district broadly parallelled the other measures of police activity in the district (offences recorded, and radio calls received for service). Districts 1 and 5 were the busiest in all three of these spheres of police activity.

The types of crisis intervention situations most frequently mentioned in the interviews were as follows:

1. The ex-psychiatric patient in crisis in the community. The police are called in by landlords, neighbours, or family when the situation with an ex-patient has reached crisis proportions. Often this has occurred after an ex-patient has stopped taking prescribed medication. Concern was expressed that these ex-patients frequently seem to have no links with any mental health worker.

2. The elderly recluse whose bizarre behaviour or squalid living conditions has caused concern. The police frequently attend these situations with public health nurses. A difficult problem is posed when the officer feels he doesn't have sufficient grounds to take the person for psychiatric assessment under Section 11 of the Mental Health Act, and the person has no family doctor willing to make a house call and complete an application for psychiatric assessment. This is often a complex problem, the basis of which is the issue as to who has the right or responsibility to interfere with a person's liberty, against his will, for his own good.

3. The apparently mentally ill person whose behaviour is repeatedly causing a nuisance or whose behaviour causes property damage. The police report they have repeat calls to the homes of these apparently mentally disordered people, but since their behaviour does not pose the threat of bodily harm, they are powerless to act under Section 11. The police advise that much time and effort is spent in trying to persuade these people to seek medical help voluntarily.

The police have suggested that a "flying squad" - a mobile mental health team including a physician or psychiatrist who can complete an application for psychiatric assessment on site - would be of great assistance to them. This concept has been discussed in the past, and the cost of its implementation appears prohibitive. This concept was also discussed during the interviews with psychiatrists as part of the present study, and the element of danger was raised.

Another concern frequently expressed during the police interviews was the length of time it took to deal with the case of someone who they brought to hospital as apparently mentally ill. Problems described related to uncertainty as to the length of time they were required to wait at the hospital before they were free to leave; the length of time they had to wait for a doctor to appear to examine the patient; the fact that the examining doctor occasionally did not ask the police officer for his information about the case. The point was made that the police provide a service to the hospital by responding to requests to bring back A.W.O.L. patients, and frequently are asked by hospitals to assist in dealing with assaultive in-patients. Some hospitals reported needing police assistance with assaultive psychiatric in-patients an average of twice a week. [45]

A forum for the discussion of such concerns has been established at the Queen Street Mental Health Centre, and is highly regarded by the officers. The Police-Ambulance Liaison Committee appears to be a useful vehicle for developing a mutual understanding between the police and the psychiatric facility.

5.3.8 Ambulance Services

The Metro Toronto Ambulance Services Department is involved in the transportation of mentally ill persons to health facilities and between health facilities. Ambulance Services is currently operating under directives issued by the Ministry of Health in 1978 in a document entitled "The Care and Transportation of the Emotionally Disturbed Patient". Ambulance Services personnel surveyed stated that more precise directives would improve their services to the mentally ill. Further direction was requested as follows:

- Under what conditions is a situation involving mentally ill persons an "emergency", with a consequent high priority for ambulance service?

- Regarding an ambulatory patient under an order for psychiatric assessment issued by a physician or a Justice of the Peace, under what conditions is a police escort necessary?

Another area of concern was the question of how long an ambulance crew has to wait at the receiving hospital after transporting a patient there for assessment.

Ambulance personnel stated further education regarding the mentally ill patient as opposed to the physically ill patient would be beneficial for their staff; they felt the staff's understanding about mental illness should be expanded.

5.3.9 Justices of the Peace

Under Section 10 of the Ontario Mental Health Act, a Justice of the Peace may issue an order for the psychiatric assessment of an individual. This order for assessment is sufficient authority for the police to take the designated individual, in custody, to an appropriate place where he may be detained for assessment. (See Appendix XV for Section 10 of the Mental Health Act.)

This section of the Act would seem to provide an avenue whereby concerned friends or relatives could have an individual, who is unwilling to seek psychiatric attention himself, taken for assessment. Frequently this avenue is a last resort for those seeking assistance for someone they believe is mentally ill.

Some Justices of the Peace, however, are reportedly reluctant to exercise this authority, thereby blocking this avenue. The order for assessment is issued at the discretion of the Justice of the Peace and it appears that some do not feel they are sufficiently knowledgeable about mental illness to make the decision to issue the order.

5.4 Conclusions and Recommendations

In accordance with the MTDHC's Mental Health Services Principles, a range of services should be provided within the crisis intervention component of the mental health service system. This would allow the necessary crisis care to be given in the least restrictive and most appropriate setting. The desired array of crisis intervention resources may be described as in Figure 6 (following page), ranging from the minimal patient involvement of Distress Lines telephone contact, to the complete patient involvement of in-patient Acute Intensive Care. The most important feature of each of the resources is accessibility. This range of resources provides a standard whereby the Metro Toronto situation regarding crisis intervention resources may be assessed.

Distress Lines

The 6 distress lines handle over 85,000 calls per year in Metropolitan Toronto. Approximately 10% - 25% of the calls involve emotional, mental, or suicidal problems. These distress lines appear to be fulfilling a need for easily accessible sympathetic listening and advice for persons seeking such assistance.

Mobile Unit

There is no mobile unit providing on-site crisis counselling to adults in Metropolitan Toronto. There is a unit providing this service to adolescents, however: the Crisis Support Team of Youthdale Treatment Centres Ltd. The Crisis Support Team provides on-call service, 24 hours a day, to any situation involving an adolescent (12 to 18 years) experiencing a crisis. In the first 11 months of operation (February 1983 - December 1983), the Crisis Support Team resolved 147 crises on-site in the community; 458 crises were resolved over the telephone. A mobile unit could be very useful in providing on-site counselling and crisis resolution to adults in crisis situations.

RESOURCE:	Distress Lines	Mobile Unit	Crisis Hostel	Crisis Centre	Emergency Services	Brief Hospital-ization	Acute Intensive Care
Primary Service(s):	Befriending, Advice	On-site counselling	Short-term accommodation, support	Intensive counselling, medication	Crisis intervention therapy, medication	Custody, crisis intervention therapy, medication	Therapy, medication
Location:	Community	Community	Community	Commumity	Hospital	Hospital	Hospital
Presently Available:	Yes	No	No	No	Yes	Minimal	Yes

FIGURE 6: CRISIS INTERVENTION RESOURCES FOR METROPOLITAN TORONTO

RECOMMENDATION #3

That in those municipalities identifying a mobile unit to provide on-site counselling and crisis resolution to adults in crisis situations as a local priority mental health service need, consultation be encouraged among local hospitals and community mental health agencies to develop a mobile unit, considering Youthdale's Crisis Support Team as one model.

Crisis Hostel

There is no crisis hostel, or "time-out" facility for mentally ill adults in stressful living environments in Metropolitan Toronto. There is an identified lack of alternatives available to the mentally ill adult who presents at the general hospital emergency service and is found to require not hospitalization, but temporary removal from a stressful living situation, and short-term support.

RECOMMENDATION #4

That in those municipalities identifying a crisis hostel for the temporary shelter of mentally ill adults from a stressful living situation as a local priority mental health service need, consultation be encouraged among local hospitals and community mental health agencies to develop such a crisis hostel. The Addiction Research Foundation's Detoxification Centres, each operated as a department of a general hospital, provide a useful model of safe accommodation, short-term support, and linkage with the appropriate services. The opportunity of using peer support - former psychiatric patients - should be encouraged in the staffing of the crisis hostel.

This description is stated in general terms to allow for the development of a crisis hostel specifically designed to meet the particular needs of each local municipality.

Crisis Centre

There is presently no residential alternative to hospitalization for adults in psychiatric crises. The Mayor's Action Task Force on Discharged Psychiatric Patients has recommended the establishment of a community crisis centre in the City of Toronto. This crisis centre would provide treatment for those in psychiatric crisis when hospitalization is inappropriate.

RECOMMENDATION #5

a) **That a Toronto Community Crisis Centre be established as recommended in The Mayor's Action Task Force Report on Discharged Psychiatric Patients, set up along the following lines:**

1. **In general, length of stay to be fewer than 7 days.** The objective is to help a person in psychiatric crisis to become stabilized sufficiently to return to the community without inappropriate hospitalization. Methods will include short-term supportive counselling; effective referral links; concrete assistance with immediate crisis related problems; access to self-help support or counselling where appropriate; medication where appropriate. Methods will not include forced medication. The expectation is of a speedy return to the community.

2. **The target clients are chronic psychiatrically disabled adults in crisis who lack supportive resources.** The Centre is not designed for involuntary clients. Initially it is anticipated that within these parameters admission criteria must be flexible. The Centre should strive to avoid a too restrictive application of "chronic psychiatrically disabled". At the same time, the target is the patient with psychiatric crises of a chronic nature - those whose needs are demonstrably neglected - and the original mandate should not be diluted.

3. **A free-standing centre located in a house-form setting in downtown Toronto.**

4. **No more than fifteen beds be available in a comfortable, non-institutional environment.** There is research available to suggest that the ideal number of residents in a crisis setting may be six to ten.

5. **The hours of operation be 7 days per week 24 hours per day, holidays and weekends included.**

6. **Funding from Ministry of Health, Community Mental Health Programs Branch.** Estimated start-up costs $644,800. Annual cost estimated at $500,000.

7. **Crisis Centre to be operated and managed by a Community Board responsible to the City of Toronto and the Ministry of Health.** Predecessor to this Board should be a group considering the details of planning and implementation. The Ministry and the City should appoint this planning group as soon as possible and membership should include local residents, service consumers and members of the Supportive Housing Coalition Sub-committee on crisis care. The eventual Board should include representation from general hospitals.

8. **Mandate be reviewed after three years of operation.** Evaluation to be based on the number of clients served, endorsement from psychiatric aftercare providers, and consumers, staff assessment, Board.

9. **Quality of staff critical to effective operation.** Centre staff to include medically trained and community trained mental health care workers as follows:

   - 1 Co-ordinator/Director
   - 6 Clinical Staff (Registered Nurses, Registered Psychiatric Nurses, Public Health Nurses, or Psychiatric Social Workers)
   - 6 Community Mental Health Care Workers
   - 1 Cook
   - 1 Secretary
   - Plus relief staff, 3 staff on duty at all times

10. **One Psychiatrist on call at all times for medical emergencies, possible admission to hospital, and prescription of medication.**

11. **Strong links be forged with the general hospitals' Emergency Departments and psychiatric units as well as case managers.** Centre is intended to be free-standing, an alternative step but not isolated from hospital or community.

12. **Effective referral links be established and maintained to and from community services.** A central objective in early stages of the program is to provide liaison with potential users of the service - hostels, consumer groups, police, boarding home operators and families.

13. **Part of preliminary process to included extensive training for staff with a view to gaining awareness of services available as detailed in the Metro Toronto District Health Council's Inventory of Adult Mental Health Services.** Similarly, a vital early task is for crisis centre staff to educate service providers and community resource groups on the Centre's role.

14. **From the inception of the program a leased car and at least one staff member be available for mobile on site community problem intervention in the City of Toronto.**

RECOMMENDATION #5

b) **That liaison be established between the City of Toronto Municipal Planning Committee and the municipal mental health services co-ordinating body.**

Hospital Emergency Services

There are specialized crisis intervention services in only three municipalities of Metropolitan Toronto: East York, Etobicoke, and Toronto. There is a need to expand these important services to patients presenting in the emergency department of general hospitals.

RECOMMENDATION #6

That appropriate space and personnel be provided in the Emergency Department of each acute care general hospital for the treatment and observation of psychiatric emergencies. Appropriate personnel would include staff trained in crisis intervention methods and familiar with community mental health care resources.

RECOMMENDATION #7

That the following University of Toronto teaching hospitals located in the downtown core of the City of Toronto develop a plan to co-ordinate their crisis intervention services: Hospital for Sick Children, Mount Sinai, St. Michael's, Toronto General, Toronto Western, Wellesley, Women's College, the Clarke Institute of Psychiatry and Queen Street Mental Health Centre.

Crisis intervention services include:

1) 24 hour, 7 day a week service
2) a multidisciplinary team
3) holding and observation rooms
4) a discrete brief hospitalization unit(s) for time-limited treatment

The treatment of patients exhibiting violent, assaultive behaviour creates difficulties for the psychiatric unit staff of general hospitals. Some hospitals have had to call the police to their in-patient unit as often as twice every week. Training programs available for the management of disruptive, assaultive behaviour would appear to be a useful course of action to pursue.

RECOMMENDATION #8

a) **That the Ministry of Health provide funding for and encourage participation in a training program for general hospital psychiatric unit staff, regarding the management of disruptive, assaultive or out of control behaviour. As well a program should be considered for hospital emergency staff and community mental health services staff.**

b) **That management guidelines or protocols be developed by each hospital regarding the response to threatening or violent behaviour by a patient in the psychiatric in-patient unit and the emergency department.**

RECOMMENDATION #9

That the Metropolitan Toronto District Health Council's Advisory Group on Co-ordination promote consultation and collaboration between the provincial psychiatric hospitals serving Metro Toronto and the general hospitals, to develop strategies to meet the service needs of the more difficult to handle psychiatric patient.

Brief Hospitalization

There are only 35 designated brief hospitalization beds in general acute care hospitals in Metropolitan Toronto. The California Model (see Appendix XVI) recommends 10 beds per 100,000 population for an adequate supply of short-term crisis care beds. Using this ratio would mean 214 short-term crisis care beds are required for Metro Toronto.

The University of Toronto Department of Psychiatry has developed an Emergency Bed Registry and has established sub-committees to examine the utilization of clinical services in the teaching hospitals.

RECOMMENDATION #10

That the University of Toronto Department of Psychiatry be commended for their initiative in establishing a co-ordinated Emergency Bed Registry and be encouraged to continue their work towards developing an example of co-ordinated psychiatric services in the teaching hospitals.

RECOMMENDATION #11

That those acute care general hospitals having no designated crisis beds for brief hospitalization be requested to establish such beds.

Acute Intensive Care

Psychiatric facilities in Metro Toronto are experiencing high occupancy rates, resulting in a lack of available beds for psychiatric crisis patients requiring hospitalization. The California model (see Appendix XVI) recommends 15 beds per 100,000 population for an adequate supply of acute intensive care beds. Using this ratio would mean 321 acute intensive care beds are required for Metro Toronto. Metropolitan Toronto currently has 645 in-patient psychiatric beds in acute care general hospitals. There is some evidence to suggest that some patients occupying in-patient beds do not require acute intensive care; however, they remain in hospital due to a lack of available community alternatives such as supportive housing.

There is great variation in the average length of stay for patients in psychiatric units of general hospitals, ranging from 8.2 days to 63.9 days. (Table 4, p. 49)

RECOMMENDATION #12

That the Metropolitan Toronto District Health Council's Advisory Group on the Co-ordination of Mental Health Services promote consultation between psychiatric facilities and community mental health agencies serving each municipality of Metropolitan Toronto to discuss solutions to the problem of the hospitalized patient who no longer requires in-patient acute intensive care but remains in hospital for lack of available alternatives. The suggested vehicle for this consultation is the recommended municipal mental health services co-ordinating body in each municipality.

Alternatives to Hospitalization

Day treatment programs provide an alternative to 24 hour a day in-patient hospitalization, thus freeing up in-patient beds. Several hospitals in Metro Toronto do not have a day treatment service.

RECOMMENDATION #13

That those acute care general hospitals without an organized day treatment program give serious consideration to the need to establish such a service themselves or with other hospitals and/or community agencies and receive appropriate funding from the Ministry of Health to provide this alternative to in-patient hospitalization.

Supportive housing programs allow patients, who might otherwise have remained hospitalized, to live in the community. When a supportive housing resident is in crisis however, the staff of the residence is in need of greater expertise in crisis intervention to provide assistance to the individual. There are presently some difficulties in obtaining this back-up support and the Crisis sub-committee of the Supportive Housing Coalition is in the process of developing formal contracts with psychiatric facilities in order to provide back-up support services to former patients.

RECOMMENDATION #14

That the Ministry of Health encourage all psychiatric facilities serving Metropolitan Toronto to establish liaison with the Supportive Housing Coalition and work with them in negotiating contracts to provide adequate back-up support services for former psychiatric in-patients in crisis.

Community Crisis-Handlers: the Police and Ambulance Services

Both the police and ambulance services play an important part in the delivery of crisis intervention services. The role of the police is important both in terms of the authority they have under the Mental Health Act, and in terms of the numbers of apparently mentally ill persons they deal with. The police experience some difficulties, however, in their contacts with hospitals when they bring persons there for psychiatric assessment. The Police-Ambulance Liaison Committee at Queen Street Mental Health Centre has proven to be a useful vehicle for the discussion of such concerns. A similar committee also exists at the Clarke Institute of Psychiatry.

RECOMMENDATION #15

That a Police-Ambulance Liaison Committee be initiated at Whitby Psychiatric Hospital, by the hospital, in order to provide a regular forum for the discussion of police, ambulance, and hospital service concerns, and in order to develop a mutual understanding and appreciation of police, ambulance, and hospital responsibilities.

The Metro Toronto Ambulance Services Department is involved in the transportation of mentally ill persons. Ambulance Services staff, however, are operating under directives that they feel would be more useful if updated and made more precise. Direction was requested, for example, as to what constitutes an "emergency" situation involving a mentally ill person, with a consequent high priority for ambulance service.

RECOMMENDATION #16

That the Ministry of Health update the 1978 guidelines provided by the Ministry to the Ambulance Service on "The Care and Transportation of the Emotionally Disturbed Patient" and provide direction regarding the definition of an "emergency" psychiatric patient.

Ambulance personnel stated that more education regarding the mentally ill patient would be of benefit for ambulance staff. More understanding of the behaviour of the mentally ill would improve their services to this group of patients, they felt.

RECOMMENDATION #17

That an educational program funded by the Ministry of Health regarding the mentally ill be developed for Ambulance Services staff to allow them to expand their understanding of the behaviour of the mentally ill and thus improve their services to this patient group.

Justices of the Peace

The Ontario Mental Health Act appears to provide an avenue whereby concerned friends or relatives can have a person who is unwilling to seek psychiatric attention, taken for assessment. A Justice of the Peace may issue an order for psychiatric assessment; however, some Justices of the Peace are hesitant to exercise this authority. It appears that some do not feel they are sufficiently knowledgeable about mental illness to make the decision to issue the order.

RECOMMENDATION #18

That the Ministry of Health in co-operation with the Ministry of the Attorney General provide funding for the development of an educational program regarding mental illness for Metropolitan Toronto's Justices of the Peace to assist them in carrying out their functions under Section 10(1) of the Mental Health Act.

SECTION IV

6. FUTURE DIRECTIONS

The mandate of the District Health Council is planning and co-ordination of services. Through its chosen focus on co-ordination, the Mental Health Care Committee has raised the expectations of the community that action will be taken in this area, and has engendered much enthusiasm and support. The example of the establishment of the Metro Toronto Emergency Services Committee to co-ordinate emergency services has reinforced these expectations for action. The time is right for progress to be made, and it is important for the MTDHC to take advantage of the current momentum to continue its focus on the co-ordination of mental health services through the establishment of the Advisory Group proposed in Recommendation #1. As stated by the first Mental Health Services Principle, it is important to ensure the disparate components of the system are brought together and made to work for the benefit of the client.

A concerted effort towards progress in the area of crisis intervention is also underway, due to the recommendations of the recently completed Mayor's Action Task Force on Discharged Psychiatric Patients, as well as to the crisis intervention planning work of the Mental Health Care Committee. Efforts must continue in the area of crisis intervention, with the MTDHC showing leadership in ensuring developments do take place in establishing a range of crisis resources.

RECOMMENDATION #19

That the Metropolitan Toronto District Health Council monitor and review developments regarding the planning and implementation of crisis intervention resources across Metro Toronto.

The University of Toronto Department of Psychiatry is presently studying emergency psychiatric services, and developing important information in this area.

RECOMMENDATION #20

That the Metropolitan Toronto District Health Council forge stronger links with the University of Toronto Department of Psychiatry in order to promote the mutual sharing of information regarding psychiatric services.

The development of municipal mental health services co-ordinating bodies in those areas where there presently are none will take time. In order to continue the focus on crisis intervention services while these bodies are being developed, the following recommendation is proposed.

RECOMMENDATION #21

That the Metropolitan Toronto District Health Council sponsor meetings of designated representatives of local hospitals and community-based mental health services in those municipalities that currently have no local co-ordinating body, to ensure that the provision of crisis intervention services is given serious consideration at the local level.

RECOMMENDATION #22

That the Metropolitan Toronto District Health Council jointly sponsor meetings of designated representatives of local hospitals and community-based mental health services with the existing municipal mental health services co-ordinating bodies, to discuss the provision of crisis intervention services at the local level.

There is a desire and expectation in the community for the MTDHC to develop a "master plan" for mental health services across Metro Toronto. Two components in this master plan have been examined: co-ordination and crisis intervention. A valuable contribution to this work was provided by the data collected for the Inventory of Adult Mental Health Services by Community Resources Consultants of Toronto.

RECOMMENDATION #23

That the Metropolitan Toronto District Health Council undertake additional analysis of the information regarding mental health resources collected for the Inventory of Adult Mental Health services in Metro Toronto, and share this information with the municipal co-ordinating bodies in order to assist them in establishing local priorities.

The MTDHC's Inventory has been widely recognized as being extremely useful to the providers of direct services and to the municipal health services co-ordinating bodies involved in planning local services.

RECOMMENDATION #24

That the Metropolitan Toronto District Health Council apply to the Ministry of Health for funding to regularly update the Inventory of Adult Mental Health Services intially published in the spring of 1983.

The eventual goal of the Mental Health Care Committee of the MTDHC is to ensure continuity of care for the mentally ill of Metro Toronto, by planning a rational, co-ordinated system of mental health services. This system will demonstrate a balance among the services in the system, and will have a comprehensive range of community-based mental health programs.

FOOTNOTES

1. Ontario Ministry of Health, Statistical Report on Community Health, (Ontario, 1980), Chapter 4.

2. See Appendix XII, "Separations From Psychiatric Facilities, April 1, 1982 to March 31, 1983," Days of Stay.

3. Ibid., Numbers of Separations.

4. L. Bachrach, Deinstitutionalization: An Analytical Review and Sociological Perspective (Rockville, Md.: National Institute of Mental Health, 1977).

5. M. Dear and M. Taylor, Not On Our Street (London: Pion Ltd., 1982), p. 47.

6. Ibid., p. 50-51.
Ontario Ministry of Health, Hospital Statistics 1981/82, Table 25, Table 26.

7. Ibid.

8. See Appendix XII, "Separations From Psychiatric Facilities April 1, 1982 to March 31, 1983."

9. Speech of the Minister of Health, the Honourable Keith Norton to the Simcoe County DHC, October 4, 1983. (Ministry of Health News Release)

10. Several of the reports had recommendations concerning services to minority groups. They were mainly the Ontario-wide reports and were concerned with French-speaking people and Native people.

11. Supportive Housing Coalition, Community Housing for Consumers of Mental Health Services in Metropolitan Toronto, September 1981.

    Community Resources Consultants of Toronto, Profile of Mental Health Housing Resources, March 1982.

    North York Inter-Hospital Committee, Housing Priorities for Discharged Psychiatric Patients, April 1982.

    Supportive Housing Coalition/City of Toronto Department of Public Health, The Housing Gap: Deficiencies in Appropriate Housing For Ex-psychiatric Patients, May 1982.

12. Community Resources Consultants and Clarke Institute of Psychiatry, Psychiatric Aftercare in Metropolitan Toronto, April 1981.

13. R. Agranoff and J. Mahler, "Mental Health Systems and the Co-ordination of Services," in Community Mental Health, ed. W. Silverman (New York: Praeger, 1981), p. 291.

14. Clarke Institute of Psychiatry Consulting Group, "Consultation Report: Systems Co-ordination for Psychiatric Services in Toronto," Toronto, June 1983, p. 6.

15. "Final Report of the Task Force to Review Primary Health Care", Dr. J. Fraser Mustard, Chairman, Toronto, December 1982, p. vii.

16. G. Heseltine, "Towards a Blueprint for Change: A Mental Health Policy and Program Perspective; Discussion Paper," Ontario Ministry of Health, December 1983, p. 6.

17. "The final report of the Mayor's Action Task Force on Discharged Psychiatric Patients," Dr. Reva Gerstein, Chairperson, Toronto, February, 1984.

18. M. Goldsmith, "From Mental Hospitals To Jails: The Pendulum Swings," Journal of the American Medical Association 250 (December 1983): 3017-3018.

G. Whitmer, "From Hospitals to Jails: The Fate of California's Deinsitutionalized Mentally Ill," American Journal of Orthopsychiatry 50 (January 1980): 65-75.

19. G. Bartolucci and C. Drayer, "An Overview of Crisis Intervention in the Emergency Rooms of General Hospitals," American Journal of Psychiatry 130 (September 1973): 953-960.

20. G. Theodorson, A Modern Dictionary of Sociology (New York: T. Y. Crowell Company, 1970), p. 88.

21. D. Aguilera and J. Messick, Crisis Intervention: Theory and Methodology (St. Louis: The C.V. Mosby Co., 1982), p. 2.

22. G. Caplan, An Approach To Community Mental Health (New York: Grune & Stratton, Inc., 1961), p. 18.

23. Aguilera, Crisis Intervention, p.65.

24. Ibid., p. 25.

25. Ibid., p. 104-106.

26. J. Brown and M. Harvey, "Psychiatric Emergencies in the General Hospital: A Review," Canadian Psychiatric Association Journal 16 (April 1971): p. 106.

27. E. Bassuk, "The Impact of Deinstitutionalization on the General Hospital Psychiatric Emergency Ward," Hospital and Community Psychiatry 31(1980): 623-627.

28. Personal Communication with James Stonehouse, Mount Sinai Hospital, April 11, 1983.

29. J. Brown and M. Harvey, "Psychiatric Emergencies in the General Hospital: A Review," Canadian Psychiatric Association Journal 16 (April 1971): p. 107

30. Ibid., p. 107.

31. Ibid., p. 107.

32. Ibid., p. 107.

33. E. Bassuk, "The Impact of Deinstitutionalization on the General Hospital Psychiatric Emergency Ward," Hospital and Community Psychiatry 31 (1980): 623-627.

34. S. Gershon and E. Bassuk, "Psychiatric Emergencies: An Overview," American Journal of Psychiatry 137 (1980): p. 3. 897.

35. Information from a mailed questionnaire survey conducted by the Association of General Hospital Psychiatric Services, Summer 1983.

36. This was the definition provided in the survey described in footnote 35.

37. W. Walker et al., "Brief Hospitalization on a Crisis Service: A Study of Patient and Treatment Variables," American Journal of Psychiatry 130 (1973): p. 896-897.

38. W. Miller, "A Psychiatric Emergency Service and Some Treatment Concepts," American Journal of Psychiatry 124 (1968): 924-933.

39. See, for example:

G. Bartolucci & C. Drayer, "An Overview of Crisis Intervention in the Emergency Rooms of General Hospitals," American Journal of Psychiatry 130 (1973):953-960.

L. Spitz, "The Evolution of a Psychiatric Emergency Crisis Intervention Service in a Medical Emergency Room Setting," Comprehensive Psychiatry 17 (1976): 99-113.

40. For 1981/82

41. For 1980/81

42. Queen Street Mental Health Centre, Facts and Figures, April 1, 1981 to March 31, 1982 (October 1982) p. 3.

43. R. Fox and P. Erickson, Apparently Suffering From Mental Disorder: An Examination of the Exercise of Police Power Under s.10 of the Mental Health Act of Ontario) (Centre of Criminology, University of Toronto, September 1972).

44. Ibid., p. 83.

45. In the last 12 months, the number of times police assisted with assaultive psychiatric in-patients at general hospitals was approximately 150. (Summer 1982 - summer 1983) Some hospitals reported no police assistance in this period; some reported needing police assistance twice a week. One hospital advised that they practise prevention with regard to assaultive patients; that is, they don't admit them.